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(Printed for the use of the Senate Committee on Finance)

IV. PROVISIONS RELATING TO MEDICARE-MEDICAID AND MATERNAL AND CHILD HEALTH

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Provisions Relating to Medicare-Medicaid and Maternal and Child Health

CONTENTS

1. PROVISIONS OF THE HOUSE BILL NOT SUBSTANTIALLY MODIFIED BY THE COMMITTEE

2. PROVISIONS OF THE HOUSE BILL SUBSTANTIALLY MODIFIED BY THE COMMITTEE

3. NEW PROVISIONS ADDED BY THE FINANCE COMMITTEE

4. PROVISIONS OF THE HOUSE BILL WHICH WERE DELETED BY THE COMMITTEE

5. ADDITIONAL MATTERS OF CONCERN TO THE COMMITTEE

STATISTICAL MATERIAL

IV. PROVISIONS RELATING TO MEDICARE-MEDICAID AND MATERNAL AND CHILD HEALTH

1. PROVISIONS OF THE HOUSE BILL NOT SUBSTANTIALLY MODIFIED BY THE COMMITTEE

Coverage for Disability Beneficiaries Under Medicare

(Sec. 201 of the bill)

The committee has given extensive consideration to proposals to provide health insurance protection under title XVIII for persons entitled as a result of disability to monthly cash benefits under the social security and railroad retirement programs. It has in past years regretfully concluded that considerations of cost precluded recommending such an extension of coverage. It is now clear that a major unmet need for health insurance protection exists among the disabled. To determine the dimensions of the health insurance problem confronting the disabled and to evaluate all the possible approaches to providing or assuring adequate health insurance for such people, the committee has in recent years directed a number of advisory councils to study this question and to report their findings and recommendations to the Congress. In each case, the council charged with responsibility for examining the issue has recommended the extension of medicare coverage to the disabled. Use of health services by people who are severely disabled is substantially higher than that by the non-disabled. Disabled workers receiving cash benefits under the social security program use about seven times as much hospital care, and about three times as much physicans' services as does the non-disabled population. These facts account both for the great need for and the substantial costs of covering the disabled under medicare. Yet the disabled have limited incomes in comparison to those who are not disabled, and most disabled persons are unable financially to purchase adequate private health insurance protection, or to obtain such insurance at all.

Accordingly, the committee bill, as is provided for in the House bill, would extend medicare protection to social security disability beneficiaries. Those covered would include disabled workers, disabled widows and disabled dependent widowers between the ages of 50 and 65, people aged 18 and over who receive social security benefits because they became disabled before reaching age 22, disabled dependent sisters and brothers, and disabled qualified railroad retirement annuitants.

The committee would also extend medicare protection to women, age 50 or older, entitled to mother's benefits who, for 24 months prior to the first month they would be entitled to medicare protection, met all the requirements for disability benefits except for actual filing of a disability claim. Under the House bill such a woman would have to wait 12 additional months after filing and becoming entitled to disabled widow's benefits before becoming eligible for medicare, because her application would have only 12 months retroactivity. The committee believes that special consideration should be given to these persons who did not file a disability claim earlier because disability determinations are too expensive to be made where no monetary benefit could, under present law, accrue to them. This special consideration would apply for a period of 12 months after the effective date of this provision (until July 1, 1974) in order that all persons who, on the effective date, would have been entitled to disability benefits for 12 to 24 or more months, could avail themselves of medicare protection at the earliest possible time. Those persons who would have been disabled for 12 months or less would, of course, be able to establish their entitlement to disability benefits at a point which would assure them medicare protection as early as possible.

The committee believes, given the cost and financing considerations involved in extending medicare coverage to the disabled, that it is imperative to proceed on a conservative basis. Consequently, the committee bill would provide health insurance protection only after the disabled beneficiary has been entitled to social security disability benefits in one or more of the disability benefit categories mentioned above for not less than 24 consecutive months. Such an approach would help to keep program costs within reasonable bounds, avoid overlapping private health insurance protection, particularly in those cases where a disabled worker may continue his membership in a group insurance plan for a period of time following the onset of his disability, and minimize certain administrative problems that might otherwise arise in cases in which entitlement to disability benefits is not determined until some time after application is made because of delays due to the appellate process. Moreover, this approach would provide assurance that the protection will be available to those whose disabilities have proven to be severe and long lasting.

Under this provision of the committee bill, medicare protection would begin with the later of (a) July 1973, or (b) the 25th consecutive month of the individual's entitlement to social security disability benefits. The House bill provides that medicare entitlement ceases at the same time that eligibility for disability benefits terminates. In a substantial percentage of these cases, disability termination is retroactive; thus, medicare coverage would also terminate retroactively. This would result in expensive administrative adjustments of individual records and would create overpayments for which in most cases, after costly development, the Social Security Administration would have to waive recovery. The committee bill would remedy this situation to the extent of extending medicare protection through the month following the month notice of termination of disability benefits is mailed.

Hospital Insurance Benefits for Uninsured Individuals

(Sec. 202 of the bill)

Present law provides hospital insurance protection under the "special transitional provision" for people who are not qualified for cash benefits under the social security or railroad retirement program. (The provision excludes an active or retired Federal employee, or the spouse of such an employee, who is covered or could have been covered under the provisions of the Federal Employees Health Benefits Act of 1959; aliens residing in the United States for less than 5 years; and people who have been convicted of a crime against the security of the United States, including sabotage, espionage, treason, etc.) The "special transitional provision" covers people who are not qualified for cash benefits under the social security or railroad retirement program and who reached aged 65 before 1968 even though they had no work under social security (or in the railroad industry). Those who attained or will attain age 65 after 1967 must have had specified amounts of work under these programs in order to be eligible for hospital insurance protection. The transitional provision will phase out as of 1974 as persons attaining age 65 in those years must be insured for cash benefits under one of the two programs in order to be eligible for hospital insurance protection.

Further, it has become very difficult for many uninsured older people to obtain private hospital insurance comparable to coverage under medicare. Since the passage of the medicare law, private insurance companies have generally changed their hospital insurance plans available to people age 65 and over to make their coverage complementary to medicare. While there is generally some type of hospital insurance available to persons age 65 and over, most of that which is offered is in the form of specified cash payment insurance, paying from $25 to $200 per week for limited periods of hospitalization. Few private health insurance companies offer their regular hospital expense plans to the aged.

The committee agrees with but has made some minor changes in the provision in the House bill which would make available hospital insurance coverage on a voluntary basis to persons age 65 and over, who are not entitled to such coverage under existing law. A State or any other public or private organization would be permitted to purchase such protection on a group basis for its retired or active employees age 65 and over. The intent is that the cost of such coverage would be fully financed through payment of a monthly premium by those who elect to enroll for this protection. During the first year, such premium would be $33 a month beginning July 1973 and would be recomputed each year and increased in the same proportion as the inpatient hospital deductible. The same restrictions on enrollment and reenrollment (including a 10-percent-per-year charge for late enrollment) would apply as now apply to enrollment for supplementary medical insurance (including the changes in such enrollment provisions made by other provisions in the bill). Aliens who have been in the United States less than five years and persons who have been convicted

of subversive crimes would be excluded from participation under this provision, just as they are excluded from enrolling for supplementary medical insurance.

The committee bill also would require that in order for persons to be eligible to enroll for hospital insurance they must also enroll for supplementary medical insurance. Those persons who have failed to enroll for supplementary medical insurance within the 3-year enrollment limit as prescribed by present law would be able, under another provision in the committee's bill to meet this requirement since they would no longer be excluded from enrolling for supplementary medical insurance. If a person terminates his supplementary medical insurance, his hospital insurance coverage under this provision would be automatically terminated effective the same date. The committee believes that such a restriction is necessary to reduce the possibility of excessive utilization of the more expensive hospital insurance coverage as might occur if an individual were enrolled for hospital insurance (covering primarily institutional care) but not for supplementary medical insurance (covering primarily outpatient care).

Amount of Supplementary Medical Insurance Premium

(Sec. 203 of the bill)

Under present law, the Secretary of Health, Education, and Welfare is directed to determine and promulgate a premium in December of each year for individuals enrolled in the supplementary medical insurance program. The dollar amount of the premium is the amount the Secretary estimates to be necessary so that the aggregate premiums for the 12-month period commencing July 1 in the succeeding year will equal one-half of the total supplementary medical insurance program costs that will be payable during that fiscal year. (The Federal Government pays the other half of the costs by matching the premium amount paid by each enrollee.) During the first five years of the program it has been necessary to increase the premium 93 percent—from $3 in July 1966 to $5.80 as of July 1972.

The committee is concerned about the increasingly severe financial burden that the premium amount, established under this method, will come to represent in future years. The premium is not only likely to continue to rise significantly but will do so without regard to the ability of beneficiaries living on reduced retirement incomes to bear the increased financial burden.

Accordingly, the committee approves the provision in the House bill which would increase the supplementary medical insurance premium in any given year only if monthly cash social security benefits had been increased in the interval since the premium was last increased. Moreover, the premium would rise by no more than the percentage by which cash benefits had been increased across the board (whether by act of Congress or automatically under the provision in the Social Security Act which provides automatic increases in cash benefits under certain circumstances). Enrollment in the supplementary medical insurance program would remain voluntary and premium payments by enrollees would still be required, but premiums would be increased

only at times and by amounts that would be related to the beneficiary's ability to meet the cost.

The revised procedure for establishing the medical insurance premium would operate as follows. The medical insurance premium would continue at $5.80 per month during fiscal 1973. Beginning in December of 1972, and each year thereafter, the Secretary would be required, as he is under present law, to determine and promulgate the monthly premium amount for the 12-month period beginning the following July. As one step in determining the premium amount, however, he would determine a monthly actuarial rate for aged enrollees representing the dollar amount he estimates will equal, in the aggregate over the 12-month period, one-half of the total benefit and administrative costs (plus a small contingency reserve) that the program will incur with respect to enrollees age 65 and over. The premium for all enrollees (including disability beneficiaries) would then be set to equal the lesser of (a) the actuarial rate described above or (b) the most recently promulgated premium rate, increased by the total percentage by which monthly cash benefits have increased or are scheduled to increase during the fiscal year to which such recently promulgated rate applies. When he promulgates the premium the Secretary would be required to issue a public statement setting forth the actuarial assumptions and bases used in arriving at the actuarial rate, and the derivation of the premium amount.

The provision approved by the committee would also authorize the appropriation from general revenues of sufficient funds to meet all supplementary medical insurance program costs above those met by the aggregate premium amounts paid by aged and disabled enrollees.

Automatic Enrollment for Supplementary Medical Insurance

(Sec. 206 of the bill)

Under present law an individual eligible for supplementary medical insurance must take the positive action of enrolling to obtain coverage for such insurance. If he does not act within the time imposed by the law, he stands to lose several months of medical insurance coverage. In recognition of the importance of timely enrollment, a concerted effort is made to notify people of their opportunity to enroll in medical insurance as they become eligible and, in fact, nearly 96 percent of eligible individuals are enrolled. Some few, however, fail to enroll at their first opportunity due, for example, to inattention, or because they are incapable of managing their own affairs.

Therefore, the committee believes, as does the House, that it would be good public policy to assure that individuals are enrolled for supplementary medical insurance when they are first eligible, unless they elect not to have the coverage. Under the bill, the aged and the disabled would be automatically enrolled for supplementary medical insurance as they become entitled to hospital insurance. Persons already receiving monthly social security or railroad retirement benefits would be deemed to have enrolled in the month before the month for which they became entitled to hospital insurance, so that their

medical and hospital insurance coverage will start at the same time. Others, not already on the cash benefit rolls, would be deemed to have enrolled for supplementary medical insurance in the month in which they file an application establishing their entitlement to hospital insurance, and their coverage under medical insurance would begin at the time specified by existing law for people enrolling in that month.

The committee has modified the House provision to exclude residents of Puerto Rico and foreign countries from the automatic enrollment provisions since it would usually be to their disadvantage to enroll. Many residents of Puerto Rico are eligible for comprehensive care under its medicaid program, which generally eliminates the need for supplementary medical insurance. Since supplementary medical insurance does not cover services or items furnished outside the United States, beneficiaries living in a foreign country would be protected only to the extent they travel to the United States for treatment.

The committee expects that persons eligible for automatic enrollment will, to the extent possible, be fully informed and given an opportunity to decline the coverage. They would be deemed to have enrolled if they do not decline coverage before it is scheduled to begin. Once their coverage has begun they would of course be free to disenroll if they wish in accordance with existing law.

The automatic enrollment provisions would be applicable only to persons who become entitled to hospital insurance after June 1973, because of the practical difficulties that would be involved in locating nonenrollees whose eligibility for medical insurance was established prior to July 1973, and giving them an opportunity to decline the coverage.

Payment Under Medicare to Individuals Covered by Federal Employees Health Benefits Program

(Sec. 210 of the bill)

Under present law, Federal employees and annuitants who are enrolled for Federal employees health benefits (FEHB) are also covered under the medicare hospital insurance plan (part A) if they have worked in employment covered by social security or railroad retirement and are eligible for monthly cash benefits under these programs. In addition, Federal employees, whether or not eligible for part A benefits, may enroll in the medicare voluntary supplementary medical insurance plan (part B) which is available to essentially all persons age 65 and over.

Part A hospital insurance protection under medicare is earned during a person's working years through a separate tax on his earnings and no payments are made by those entitled to benefits after they have stopped working. In contrast, persons who are eligible for health insurance protection under a FEHB plan continue to pay the same premium rates for their coverage after retirement (on the basis of age or disability) as they did when they were active employees (although the coverage may be more valuable since older and disabled people use more medical services). The Federal Government currently pays about 40 percent of the overall cost of FEHB protection.

When the medicare program was enacted in 1965, it was intended that it would provide basic health insurance protection for people age 65 and over and that it would pay its benefits in full without regard to any other benefits that might be payable under an employee health benefits plan. At the same time, it was expected that such plans would adjust their benefit policies to complement the protection provided under medicare rather than to duplicate the benefits. Under the committee bill the medicare program would be extended to (1) persons entitled to monthly cash benefits under the social security and railroad retirement programs after they had been entitled to disability benefits for at least 2 years and, (2) certain individuals age 60 to 64. It is the committee's intention that, under medicare, the disabled and others under age 65 will be afforded the same basic health care protection as those age 65 and over and that employee health plan policies will be adjusted to complement the protection provided under medicare rather than duplicate the benefits.

Unlike most employers, the Federal Government has not arranged the health insurance protection it makes available to its employees age 65 and over or to its annuitants so that such protection would be supplementary to medicare benefits. It is true, however, that some individual plans have afforded more protection to those enrollees with medicare coverage than those without such coverage.

Although most Federal employment covered by a Federal staff retirement system is excluded from social security coverage, many Federal employees become insured under social security on the basis of other employment. About 50 percent of retired and active Federal employees age 65 and over are entitled to hospital insurance benefits under medicare.

Several problems arise under the present situation. The FEHB plans cover many of the same health care expenses that are covered under medicare. In cases where health care expenses are covered under both medicare and a Federal employee plan, the medicare benefits are paid first, and the Federal employee plan then pays its benefits in an amount which, when added to the benefits payable under medicare, may not exceed 100 percent of the expenses allowable under the FEHB plan.

A Federal employee who is covered under a high-option FEHB plan as well as the medicare plans has somewhat better protection than is afforded under the FEHB plan alone. But, because of the nonduplication clauses in the FEHB contracts, he does not derive the full value of the protection of the FEHB contracts. If a Federal annuitant entitled under medicare cancels his enrollment under a FEHB plan because of the high total cost of his health care protection he will lose the high level of protection he previously enjoyed under the FEHB program at an age where his health care costs can be expected to increase substantially.

Federal annuitants and employees who are covered under a FEHB plan generally do not find it advantageous to enroll in the medicare voluntary supplementary medical insurance plan, because of the overlapping of FEHB benefits and benefits under the supplementary plan. Thus, Federal annuitants and employees do not receive the advantage available to virtually all other persons eligible to enroll in the supplementary medical insurance program, of the 50-percent Government contribution toward the cost of the protection.

In order to assure a better coordinated relationship between the FEHB program and medicare and to assure that Federal employees and annuitants will eventually have the full value of the protection offered under medicare and FEHB, the committee has approved a provision in the House bill which would provide that effective January 1, 1975, the medicare program (both parts A and B) would not pay for any otherwise covered service if such service is covered under the FEHB plan in which the beneficiary to whom the service was provided is enrolled. This provision would not go into effect (or would be suspended, if already in effect) if the Secretary of Health, Education, and Welfare certifies that the FEHB program has been so modified as to assure (1) that there is available to Federal employees or annuitants one or more Federal health benefit plans which offer protection supplementing the combined protection of parts A and B of medicare, the protection of Part A alone, and the protection of part B alone, and (2) that the Government is making a contribution toward the health insurance of all Federal employees or annuitants which is at least equal to the contribution it makes for high option coverage under Governmentwide FEHB plans. Nor would this provision apply with respect to an individual plan if the Secretary of Health, Education, and Welfare certifies that such plan (1) has made available to its enrollees entitled to medicare protection supplementing the combined protection of parts A and B of medicare, the protection of part A alone, and the protection of part B alone, and (2) is making a contribution toward the health insurance of its enrollees entitled to medicare which is at least equal to the contribution made by the Federal Government for high option coverage under Governmentwide FEHB plans. The contribution, whether by the Federal Government or by the individual plan, could be in the form of a contribution toward the supplementary FEHB protection or a payment to or on behalf of the individual employee or annuitant to offset the cost of his purchase of medicare protection, or a combination of the two. The Secretary would, of course, prepare his certification on the basis of information he obtains from the Civil Service Commission about the characteristics and operations of each of the various plans as well as the Federal program as a whole. It is the hope and the intent of the committee and the Committee on Ways and Means that the Secretary will be able to make this certification for each of the plans under the FEHB program before January 1975. A similar provision was approved by the committee in 1970 and included in H.R. 17550 as passed by the Senate.

Limitation on Federal Participation for Capital Expenditures

(Sec. 221 of the bill)

Under title XVIII depreciation on buildings and equipment, and interest on loans used to acquire them, are reimbursable as part of the cost of providing services to medicare beneficiaries. Such reimbursement is paid without regard to whether the items were constructed or purchased in conformity with any type of health facility planning requirement. Similarly, reimbursement on a cost basis for inpatient hospital services provided under titles V (maternal and child health) and XIX (medicaid) of the Social Security Act includes a recognition

of certain capital costs without regard to conformance to planning requirements.

There are few aspects of the health care system in the United States which have been so thoroughly explored as the need for comprehensive areawide planning for the development and utilization of all types of health care facilities. But the acceptance of the purposes of State and areawide health facility planning has not always been matched by purposeful application of the incentives required to achieve the end result of such planning. Thus, while a significant amount of Federal money is currently being expended under the comprehensive health planning provisions of the Public Health Service Act in the interest of furthering health facility planning at the State and local levels, Federal funds are being expended for health services provided under medicare, medicaid, and the maternal and child health programs without regard to whether the facilities providing the services are cooperating in such health facility planning. The committee and the Committee on Ways and Means believe that the connection between sound health facility planning and the prudent use of capital funds must be recognized if any significant gains in controlling health costs are to be made. Thus, the committee believes it is necessary to assure that medicare, medicaid, and the maternal and child health programs are consistent with State and local health facility planning efforts, in order to avoid paying higher costs unnecessarily in the future where these costs result from duplication or irrational growth of health care facilities.

At present, efforts are being made on the Federal, State, and local levels to assure that the need for the expansion and modernization of health facilities is evaluated, coordinated, and planned on a rational and controlled basis. At the Federal level, comprehensive health planning legislation provides for Federal grants for the establishment and funding of areawide and comprehensive State health care planning agencies. Currently, all 50 States, the District of Columbia, and five territories have State comprehensive health planning agencies. It is estimated that 200 areawide planning agencies are receiving grants and that about 125 of such agencies are operational.

To avoid the use of Federal funds to support unwarranted capital expenditures and to support health facility and health services planning activities in the various States, the committee has approved, with a minor change concerning health care facility construction which was already in progress, the House provision which would authorize the Secretary of Health, Education, and Welfare to withhold or reduce reimbursement amounts to providers of services and health maintenance organizations under title XVIII for depreciation, interest, and, in the case of proprietary providers, a return on equity capital, related to certain capital expenditures that are determined to be inconsistent with State or local health facility plans. (Similar authority would be provided with respect to the Federal share of payment for inpatient hospital care under titles V and XIX.) Capital expenditures for the purposes of this provision include expenditures (1) for plant and equipment in excess of $100,000; (2) which change the bed capacity of the institution; or (3) which substantially change the services provided by the institution. Where the expenditures are in the form of rental expenses for facilities or equipment which would have been excluded

from reimbursement if they had been acquired by purchase, the Secretary would disallow the "higher" of the actual rental expenses or an amount which he finds to be the reasonable equivalent of the amount which would have been excluded from reimbursement if the facilities or equipment had been purchased. The Secretary would take such action on the basis of findings and recommendations submitted to him by various qualified planning agencies. If he determines, however, after consultation with an appropriate national advisory council, that a disallowance of capital expenses would be inconsistent with effective organization and delivery of health services or effective administration of titles V, XVIII, or XIX, he would be authorized to allow such expenses.

The Secretary would be authorized to enter into agreements with the States under which designated planning agencies would submit their findings and recommendations (along with those of other qualified planning agencies) with respect to proposed capital expeditures that are inconsistent with the plans developed by such agencies. It is generally expected that the agency will be the agency established under section 314(a) of the Public Health Service Act. (All such health facility and health services planning agencies must have governing bodies or advisory bodies at least half of whose members represent consumer interests.) An adverse decision by a State planning agency may be appealed to an appropriate agency or individual at the State level. The Secretary would be authorized to pay from the Federal Hospital Insurance Trust Fund the reasonable costs incurred (on an estimated or proportionate basis without necessarily specific and highly detailed cost-finding of costs with respect to each facility decision undertaken) by the planning agencies in preparing and forwarding findings and recommendations. The bill would in no way change the autonomy or authority of existing State or local planning agencies, or the relationships between such agencies, either within States or across State lines.

It is not intended that any new planning agencies be established where existing State and local agencies are available and capable of assuming necessary responsibility. The statewide agency may make use of local agencies to assist it. Existing local planning agencies should be utilized, however, only to the extent that they are broadly representative of health care interests in the community. The Secretary should assure himself that a local planning agency selected to make such recommendations to the statewide agency is broadly representative of the interests of various types of health care and services and that no single type of facility or service would control the planning and approval mechanism. Additionally, such local agencies should employ or regularly utilize the services of personnel knowledgeable in health care planning. It is expected that decisions to approve capital expenditures would be made only after thorough consideration has been given to alternative health care resources already available in the area or approved in a given community or medical service area, including outpatient and other alternative sources of care which may lead to reduced needs for inpatient beds. The statewide agency with overall responsibility should, wherever possible, be the Comprehensive Health Planning Agency.

These limitations generally would be effective with respect to obligations for capital expenditures incurred after December 31, 1972 or earlier, if requested by the State. However, the committee modified the House bill to, as indicated above, make the provision inapplicable to construction toward which preliminary expenditures of $100,000 or more had been made in the 3-year period ending December 17, 1970, the date on which the amendment providing a similar exception was offered to H.R. 17550.

Limitations on Coverage of Costs Under Medicare

(Sec. 223 of the bill)

The committee is mindful of the fact that costs can and do vary from one institution to another as a result of differences in size, in the nature and scope of services provided, the type of patient treated, the location of the institution and various other factors affecting the efficient delivery of needed health services. The committee is also aware, however, that costs can vary from one institution to another as a result of variations in efficiency of operation, or the provision of amenities in plush surroundings. The committee believes that it is undesirable from the standpoint of those who support Government mechanisms for financing health care to reimburse health care institutions for costs that flow from marked inefficiency in operation or conditions of excessive service.

To the extent that differences in provider costs can be expected to result from such factors as the size of the institution, patient mix, scope of services offered or other economic factors, wide, but not unlimited recognition should be given to the variations in costs accepted as reasonable. However, data frequently reveals wide variations in costs among institutions that can only be attributable to those elements of cost that would ordinarily not be expected to vary substantially from one institution to another.

Where the high costs do in fact flow from the provision of services substantially in excess of or more expensive than generally considered necessary to the efficient provision of appropriate patient care, patients may nevertheless desire such services. It is not intended that patients who desire unusually expensive service should be denied the service. However, it is unreasonable for medicare or medicaid (which are financed by almost all people in the country rather than the patient or community that wants the expensive services) to pay for it.

Similarly when the high costs flow from inefficiency in the delivery of needed health care services the institution should not be shielded from the economic consequences of its inefficiency. Health care institutions, like other entities in our economy should be encouraged to perform efficiently and when they fail to do so should expect to suffer the financial consequences. Unfortunately a reimbursement mechanism that responds to whatever costs a particular institution incurs presents obstacles to the achievement of these objectives. The committee believes that the objectives can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management.

84-378 O - 72 - 2

Present law provides authority to disallow incurred costs that are not reasonable. However, there are a number of problems that inhibit effective exercise of this authority. The disallowance of costs that are substantially out of line with those of comparable providers after such costs have been incurred creates financial uncertainty for the provider, since, as the system now operates, the provider has no way of knowing until sometime after it incurs expenses whether or not they will be in line with expenses incurred by comparable providers in the same period. Furthermore, present law generally limits exercise of the authority to disallow costs to instances that can be specifically proved on a case-by-case basis. Clear demonstration of the specific reason that a cost is high is generally very difficult. And, since a provider cannot charge a beneficiary more than the program's deductible and coinsurance amounts for covered services, exercise of either type of authority can leave the provider without reimbursement for some costs of items or services it has already incurred for patients treated some time ago. Under these circumstances the provider would have to obtain funds from some other source to make up for its deficit.

Accordingly, the committee has approved a provision in the House bill which would authorize the Secretary of Health, Education, and Welfare to set limits on costs recognized as reasonable for certain classes of providers in various service areas. This authority differs from existing authority in several ways and meets these problems. First, it would be exercised on a prospective, rather than retrospective, basis so that the provider would know in advance the limits to Government recognition of incurred costs and have the opportunity to act to avoid having costs that are not reimbursable. Second, the evaluation of the costs necessary in delivering covered services to beneficiaries would be exercised on a class and a presumptive basis—relatively high costs that cannot be justified by the provider as reasonable for the result obtained would not be reimbursable—so that implementation of the proposed authority would appear more feasible than present authority. Third, since the limits would be defined in advance except with respect to emergency care, provision would be made for a provider to charge the beneficiary for the costs of items or services substantially in excess of or more expensive than those that are determined to be necessary in the efficient delivery of needed health services. Public notice would be provided where such charges are imposed by the institution and the beneficiary would be specifically advised of the nature and amount of such charges prior to admission so that there is opportunity for the public, doctors, and their medicare patients to know what additional payment would have to be made. The committee expects that the provision will not be applicable where there is only one hospital in a community—that is, where, if the provision were applied, additional charges could be imposed on beneficiaries who have no real opportunity to use a less expensive, non-luxury institution, and where the provision would be difficult to apply because comparative cost data for the area are lacking.

The committee, along with the Committee on Ways and Means, recognizes that the initial ceilings imposed will of necessity be imprecise in defining the actual cost of efficiently delivering needed health care. And the committee recognizes that these provisions

will apply to a relatively quite small number of institutions. The data that are available for this purpose will often be less than perfectly reliable—for example, it may be necessary to use unaudited cost reports or survey or sampling techniques in estimating the costs necessary to the efficient delivery of care. Under medicare's administrative system, however, cost reports prepared by the providers are now being submitted more promptly after the close of the accounting period and should be available for analysis in the next year and for the establishment of limits in the second following year. Also, the precision of the limits determined from these data will vary with the degree to which excessive costs can be distinguished from the provision of higher quality or intensity of care.

For costs that would not generally be expected to vary with essential quality ingredients and intensity of medical care—for example, the costs of the "hotel" services (food and room costs) provided by hospitals—the Secretary might set limits sufficiently above the average costs per patient day previously experienced by a class of hospitals to make allowance for differing circumstances and short-term economic fluctuations. Hotel services may be easiest to establish limits for and be among the first for which work can be completed. Attention might be given as well to laundry costs, medical record costs, and administration costs within the reasonably near future.

Setting limits on overall costs per patient day and specific costs that vary with the quality and intensity of care would be more difficult, but the Secretary might be able to set reasonable limits sufficiently above average costs per patient day previously experienced by a class of institutions so that only cases with extraordinary expenses would be subject to any limits. In addition, special limits could be established on cost elements found subject to abuse. For example, the Secretary might establish limits on the level of standby costs that would be recognized as reasonable under the program to prevent Government programs from picking up the cost of excessive amounts of idle capacity—particularly relatively high personnel costs in relation to patient loads where occupancy rates are low—in reimbursing for services to covered patients.

Providers would, of course, have the right to obtain reconsideration of their classification for purposes of cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception.

For other than emergency care, providers will be permitted to collect costs in excess of the medicare ceilings from the beneficiary (except in the case of admission by a physician who has a direct or indirect financial interest in a facility) where these costs flow from items or services substantially in excess of or more expensive than those necessary for the effective delivery of needed services, provided all patients are so charged and the beneficiary is informed of his liability in advance. Information on additional charges assessed would also be made available generally in the community. The committee is also requesting that the Secretary submit annually to it a report identifying the providers that make such additional charges to beneficiaries and furnishing information on the amounts being charged by such providers.

The determination of the cost of the excess items or services for which the beneficiary may be charged will be made on the basis of costs previously experienced by the provider. For example, if costs for food services experienced in 1969 among a group of hospitals in an area ranged from $4 to $9 a day with a median cost of $5 a day and the limit for food services set by the Secretary for 1971 was $7.20 a day, the hospital previously experiencing costs of $9 a day could charge patients $1.80 a day for food services. However, should total reimbursement for covered services from the program plus charges billed for such services exceed actual costs in any year, the excess will be deducted from payments to the provider. Thus, the provider would not profit from charges to beneficiaries based on excess costs in the prior year.

In addition it should be noted that the fact that a provider's costs are below the ceilings established under this provision will not exempt it from application of the ceiling of customary charges where such charges are less than cost under another provision in the committee bill.

The provision would be effective with respect to accounting periods beginning after December 31, 1972.

Limits on Prevailing Charge Levels

(Sec. 224 of the bill)

Under present administrative policies under medicare, the prevailing limit on the reasonable charge for a service is intended, over the long run, to be set at a level no higher than is necessary to embrace the 75th percentile of customary charges for that service in the physicians' locality. To illustrate, if customary charges for an appendectomy in a locality were at five levels, with 10 percent of the services rendered by physicians whose customary charge was $150, 40 percent rendered by physicians who charge $200, 40 percent rendered by physicians who charge $250 and 5 percent rendered by physicans who charge $300 and with the remaining 5 percent rendered by physicians charging in excess of $300, the prevailing limit would be $250, since this is the level that, under medicare regulations would cover at least 75 percent of the cases.

Customary charges for services that are within the prevailing fee limit are generally recognized in full. Normally, only a relatively small number of situations are affected by additional rules used to judge the reasonableness of charges. In fiscal 1973, however, the increase in allowed charges is to fall under the limitations established by price stabilization policies.

The committee, as well as the Committee on Ways and Means, believes that it is necessary to move in the direction of an approach to reasonable charge reimbursement that ties recognition of fee increases to appropriate economic indexes so that the program will not merely recognize whatever increases in charges are established in a locality but would limit recognition of charge increases to rates that economic data indicate would be fair to all concerned and follow rather than lead any inflationary trends.

Under the provision approved by the committee, the prevailing charges recognized for a locality could be increased in fiscal year 1974

and in later years only to the extent justified by indexes reflecting changes in the operating expenses of physicians and in earnings levels. What the bill provides is a limit on the increases that would be recognized on the basis of the other reasonable charge criteria. Increases in the customary charges of individual physicians and in the charges prevailing among physicians in a locality would continue to be recognized only on the basis of adequate evidence that such increases had been in effect for a period of time. The new ceiling on recognition of increases in prevailing charge limits that is provided would come into play only when the adjustments necessary to meet increases in the actual charges prevailing in a locality exceeded, in the aggregate, the level of increase justified by other changes in the economy.

For purposes of this amendment a "locality" would be defined as an area of a size and nature permitting proper calculation and determination of the types required to adjust prevailing charge levels.

The Secretary would establish the statistical methods that would be used to make the calculations to establish the limit on the increases allowed by this provision.

The base for the proposed economic indexes would be calendar year 1971. The increase in the indexes that occurs in a succeeding calendar year would constitute the maximum allowable aggregate increase in prevailing charges that would be recognized in the fiscal year beginning after the end of that calendar year.

Initially, the Secretary would be expected to base the proposed economic indexes on presently available information on changes in expenses of practice and general earnings levels combined in a manner consistent with available data on the ratio of the expenses of practice to income from practice occurring among self-employed physicians as a group. If, for example, available data indicated that for self-employed physicians as a group, expenses of practice absorbed approximately 40 percent of gross receipts of practice (the proportion indicated by data compiled by IRS from tax returns), the Secretary could determine that the maximum aggregate increase in prevailing charge levels that could be recognized would be 40 percent of the increase in expenses of practice indicated by IRS data plus 60 percent of the increase in earnings levels indicated by social security data. Thus, if during calendar year 1972 the area increase in expenses of practice was 3 percent and the area increase in earnings was 5 percent, the allowable aggregate increase in prevailing charges recognized by the carrier in each locality during fiscal year 1974 would be 4.2 percent:

$$(.40\times.03)+(.60\times.05)=.042$$

The carrier would apply the prevailing charge criteria now in the law to data on charges in calendar year 1972 to determine the increases in prevailing charges that it would be appropriate to recognize during fiscal year 1974. If the aggregate increase in prevailing charges so determined was less than 4.2 percent, the adjustments would be permitted and the portion of the allowable aggregate increase not used in that fiscal year could be carried forward and used in future fiscal years. However, if the aggregate increase in prevailing charges found otherwise appropriate exceeded 4.2 percent, such increases would be

reduced to the extent necessary to bring the aggregate of all increases within the 4.2 ceiling.

It is, of course, contemplated under the bill that the Secretary would use, both initially and over the long run, the most refined indexes that can be developed. However, the committee believes that the viability of the proposal does not depend on a great deal of further refinement. The objectives of the proposal could be attained with equity through the use of an approach such as that described above. This is so because the indexes are not to be applied on a procedure-by-procedure basis that would raise serious questions of equity in absence of refinements to take account of variations in the mix of factors of production among various types of medical services and to take account of changes in productivity with respect to various services. Rather, the indexes will operate as overall ceilings on prevailing fee level increases recognized in a carrier area under which adjustments permitted by the present customary and prevailing charge criteria could be made to take account of the shifting patterns and levels and actual charges in each locality. Thus, whether the new limit on prevailing charges will actually affect the determination of reasonable charges depends on the degree to which physicians' fees rise in the future. If the rise in fees in the aggregate was no more than the rise in operating expenses of physicians and in earnings, the rise in fees would be allowed in full.

The committee, along with the Committee on Ways and Means, believes it desirable to embody in the statute the limitations on medical charges recognized as prevailing now set forth in medicare regulations under which no charge may be determined to be reasonable if it exceeds the greater of the prevailing charge recognized by the carrier and found acceptable to the Secretary for similar services in the same locality on December 31, 1970, or the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year.

The committee believes that it is essential to implementation of the original congressional intent that the Department of Health, Education, and Welfare require that in an area where a significant number of payments are made under Blue Shield and other service benefit and insurance contracts and to the extent such payments are generally accepted by physicians as payment in full, they should be properly reflected in the charge data used in the determination of reasonable charges. Under service benefit plans, for example, the participating physician agrees to accept the Blue Shield allowance as payment in full for services to patients with incomes below specified limits. Where the actual number of cases in which the Blue Shield payment represents payment in full is unknown and valid estimates cannot be obtained, reasonable presumption should be drawn from the number and probable income levels of those covered by service benefit contracts and whether such income levels would generally encompass most beneficiaries and as to the number of instances in which the Blue Shield payment would usually represent the physician's full payment.

While relating the allowability of future increases in prevailing charges to general economic indicators is an appropriate method for reasonable charge determinations with respect to the services of physi-

cians, the committee believes it would be inappropriate for reasonable charge determinations with respect to medical supplies, equipment, and services that do not generally vary in quality from one supplier to another. This is so because no program purpose would be served by allowing charges in excess of the lower levels (the comparable House provision referred to "lowest levels") at which supplies, equipment, or services can be readily obtained in a locality. For this reason, the committee bill permits deviation from generally applicable reasonable charge criteria where it is determined that medical supplies, equipment, and services do not generally vary in quality from one supplier to another.

The committee recognizes that it will not be possible for the Secretary to immediately establish special charge or cost limits for every item or service not materially affected in quality by the supplier who actually furnishes it to the patient. However, the committee believes that it is important to make explicit the Secretary's authority and it is expected that he will assert such authority to impose rules for determining reasonable charges when, after due consideration, he determines that a particular item or service does not vary in quality from one supplier to another and devises special rules for reasonable charge determinations that he considers equitable and administratively feasible. Until the Secretary designates an item or service as falling within the scope of this provision and establishes rules for determining reasonable charges for that item, the presently applicable rules, including any special rules imposed by the carrier, would generally remain in effect.

The committee believes that it would be advisable for the Secretary to give priority attention to items of service or equipment most frequently paid for under the program. The committee also believes that there are certain items of service for which special reasonable charge rules can be readily established. Where a separate charge is made by a physician for an injection, for example, the maximum allowance should be a scheduled amount based upon the approximate ingredient and supply cost plus a modest specified amount (such as $1 or $2) to cover the injection service. This seems reasonable since an injection generally is not a service requiring a high level of training and experience; paramedical personnel are normally capable of providing and often provide the service. Similarly, schedules of allowances should be established by geographic or medical service area, where appropriate, for routine laboratory work—including interpretation of results—for tests not ordinarily included in the charge for a physician's visit. The scheduled allowance should be based on the costs of tests (including common groupings of tests) when undertaken by qualified, efficient and economical sources—such as independent automated laboratories—to which physicians in an area have reasonable access.

While the provision discussed above, which would be applicable beginning January 1, 1973, is directed to items and services that do not generally vary in quality from one supplier to another, the committee notes that present law provides authority for special reasonable charge rules and limits with respect to any item or service for which such special rules are found to be necessary and appropriate. The committee believes that it is reasonable and desirable to limit charges recognized for routine follow-up visits to institutionalized patients

to a reasonable proportion of charges for the initial visit and to limit charges recognized for visits on the same day to a number of patients in the same institution to amounts that are reasonable in relation to the time usually spent and services provided under such circumstances. Of course, such limitations would not preclude individual consideration of requests for higher allowances where such followup visits or multiple visits are justifiable as being nonroutine.

The effect of the new limits established under this provision would be extended to the medicaid and child health programs by providing that payments under these programs after enactment of the bill may not be made with respect to any amount paid for items and services which exceeds these new limits. This would be consistent with policy in the present medicaid program.

The medicaid provisions of the Social Security Amendments of 1965 contained nothing which attempted to limit the charges by physicians that States could pay under their medicaid programs. States could and usually have set some type of limits of their own, typically less than usual or customary charges. The Social Security Amendments of 1967 added a new medicaid provision which required that a State plan must provide assurances that "payments (including payment for any drugs under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care."

On November 11, 1971, HEW issued regulations which limited fees paid to physicians, dentists, and other individual providers of medical services under medicaid. The regulation stipulated that in no case could payment exceed the highest of:

(1) Beginning July 1, 1971, the 75th percentile of customary charges in the same localities established under title XVIII during the calendar year preceding the fiscal year in which the determination is made.

(2) Prevailing charge recognized under part B, title XVIII for similar services in the same locality on December 31, 1970.

(3) Prevailing reasonable charge recognized under part B, title XVIII.

Under the House bill, the Health Insurance Benefits Advisory Council is directed to study the methods of reimbursement for physicians' services under medicare and to report to the Congress by July 1, 1972, on how these methods affect physicians' fees, the extent to which they increase or decrease the number of cases for which physicians accept assignments, and the share of total physician charges which beneficiaries must pay. It is clear, however, that the group will be unable to complete the study requested by the House by July 1, 1972. The committee has therefore extended the deadline to January 1, 1973 so that HIBAC may comply with the House request.

The proposed amendment is substantially along the lines of the present regulation, and would be effective upon enactment.

Payment for Supervisory Physicians in Teaching Hospitals

(Sec. 227 of the bill)

When medicare was enacted, the general expectation was that physicians' services to patients (but not intern or resident services) would generally be paid for on a fee-for-service basis. However, the issue of

how medicare should reimburse for the services of a physician when he supervised interns and residents in the care of patients was not specifically detailed. Nevertheless, it was clear that charges paid for a physician's services under medicare should be reasonable in terms of both the patient care services that a particular physician provided as well as the charges made for similar services to other patients—that is, if a physician merely took legal responsibility for care, no fee for service was intended to be paid. Or, if the physician performed the services differently than is usually done when a patient engages his own private physician, the differences were to be reflected in the charge paid by medicare.

Under present law, hospitals are reimbursed under the hospital insurance part (part A) of the medicare program for the costs they incur in compensating physicians for teaching and supervisory activities and in paying the salaries of residents and interns under approved teaching programs. In addition, reasonable charges are paid under the medical insurance program (part B) for teaching physicians' services to patients.

There is a wide variety of teaching arrangements. At one extreme there is the large teaching hospital with an almost exclusively charity clientele in which the treatment of medicare beneficiaries may, in fact, though not in law, be turned over to the house staff; in such hospitals many teaching physicians have had the roles exclusively of teachers and supervisors and have not acted as any one patient's physician. Since in these cases the services of the teaching physicians are primarily for the benefit of the hospital teaching program and hospital administration rather than being focused on the relationship between doctor and patient, the services of these physicians should be reimbursed as a hospital cost rather than on a fee-for-service basis under the supplementary medical insurance program.

At the other extreme, there is the community hospital with a residency program which relies in large part for teaching purposes on the private patients of teaching physicians whose primary activities are in private practice. The private patients contract for the services of the physician whom they expect to pay and on whom they rely to provide all needed services. The resident or intern normally acts as a subordinate to the attending physician, and the attending physician personally renders the major identifiable portion of the care and directs in detail the totality of the care. Moreover, there are teaching hospitals in which a teaching physician may be responsible both for private patients whom he has admitted and for patients who have presented themselves to the hospital for treatment at no cost and who have been assigned by the hospital to his care.

It has proved to be difficult to achieve effective and uniform application of present policies to the large number of widely varying teaching settings. In some cases, charges have been billed and paid for services rendered in teaching hospitals which clearly did not involve any degree of teaching physician participation. In some cases charges were billed for the services that residents and interns rendered in every case where a supervising physician had overall responsibility for their actions, even though he may not actually have become involved in the patient's care. In other cases, charges for covered services were billed in amounts that were out of all proportion to the covered service or the charges billed to other patients.

In the typical community hospital and other teaching settings where patients are expected to pay fees for these services, fee-for-service payment for physicians' services would continue to be made by the medicare program. For example, payment for the services a community physician provides to his private patient is clearly in accord with the usual practices of other health insurance programs and patients who pay their bills out of pocket.

On the other hand, in the case of all the ward or other accommodations in many large hospitals and the service wards of other teaching institutions where patients are not expected to pay any fees for physicians' services or only reduced fees are normally paid, the payment of full charges represents an expense to the program that is not necessary to give medicare patients access to the care they receive, Also, the payments tend to support the maintenance of two classes of patients in some cases.

To deal with these problems, H.R. 1 as passed by the House and approved by the committee, contains a provision, originally developed by this committee in 1970, which would provide that reimbursement for services of teaching physicians to a nonprivate medicare patient should be included under part A, on an actual cost or "equivalent cost" basis. A mechanism for computing payment for services of supervisory physicians on the unpaid voluntary medical staff of a hospital would be developed on a reasonable "salary equivalency" basis of the average salary (exclusive of fringe benefits) for all full-time physicians (other than house staff) at the hospital or, where the number of full-time salaried physicians is minimal, at like institutions in the area. The committee expects that any determination with respect to whether the size of a particular hospital's salaried staff is sufficient to provide the proper basis for reimbursement of donated services would take into account the ratio of salaried to voluntary nonpaid staff members as well as the absolute number of salaried staff. The average salary equivalent, which would be distilled into a single hourly rate covering all physicians regardless of specialty, would be applied to the actual time contributed by the teaching physician in direct patient care or supervision on a regularly scheduled basis to nonprivate patients. Such services would be reimbursed to a fund designated by the organized medical staff.

Medicare would pick up its proportionate share of such costs on a basis comparable to the method by which reimbursement is presently made for the services of interns and residents. The salary-equivalent allowance would provide reasonable and not excessive payments for such services. The payment represents compensation for contributed medical staff time which, if not contributed, would have to be obtained through employed staff on a reimbursable basis. Medicare payments for such services would be made available on an appropriate legal basis by the fund to the organized medical staff for their disposition for purposes such as payment of stipends enhancing the hospital's capacity to attract house staff or to upgrade or to add necessary facilities or services, the support of continuing education programs in the hospital, and similar charitable or educational purposes. Contributions to the hospital made by the staff from such funds would not be recognized as a reimbursable cost when expended by the hospital nor would depreciation expense be allowed with respect to equipment or facilities donated to the hospital by the staff.

Fee-for-service would continue to be payable for medicare beneficiaries who are bona fide "private patients." This would ordinarily be a patient who was seen by the physician in his office prior to hospital admission; for whom he arranged admission to the hospital, whose principal physicians' services were provided by him, who was visited and treated by him during his hospital stay; who would ordinarily turn to him for followup care after discharge from the hospital; and who is legally obligated to pay the charges billed, including deductibles and coinsurance, and from whom collection of such charges is routinely and regularly sought by the physicians. To facilitate efficient administration, a presumption may be made that all of the patients in an institution, or portion of an institution, are private patients but only where the institution offers satisfactory evidence that all patients are treated the same with respect to arrangements for care and accommodations, that all patients receive their principal physician services from an attending physician, and that all of the patients are billed for professional services and the great majority pay. Of course, appropriate safeguards should be established to preclude fee-for-service payment on the basis of pro forma or token compliance with these private patient criteria.

It is recognized, however, that this concept of a private patient is not a complete definition primarily because it does not take account of the customary arrangements for reimbursing consultants and specialists who are not serving as the patient's attending physician, but who may provide a service to the patient for which a fee-for-service payment is appropriate and for which services the patient is legally obligated and which he expects to pay. For example, where a general practitioner refers his patient to a surgeon for necessary operative work and where the surgeon ordinarily charges and collects from all referred patients for his services.

In some cases hospitals that normally do not bill for physician services have special centers, such as a center for severely burned people, where patients able to pay are regularly admitted and pay charges. It would be intended that medicare follow the pattern of the private patient in such centers. Also, the outpatient department of a hospital may organize the provision of and billing for physicians' services in that department differently from the inpatient setting. In such cases, the decision regarding whether cost or charge reimbursement is appropriate should be made separately for inpatients and outpatients. However, if the services are contracted for on a group basis, and medicare and medicaid directly or indirectly pay for such services, the normal basis of reimbursement by the two programs would be one of cost if the services are provided by a directly or indirectly related organization.

The second exception to the cost-reimbursement coverage of teaching physician services is intended to permit the continuation of fee-for-service reimbursement for professional services provided to medicare patients in institutions which traditionally billed all patients (and the majority of whom paid) on a fee or package charge basis for professional services. This exception would apply if, for the years 1966, 1967, and each year thereafter for which part B charges are being claimed: all of the institution's patients were regularly billed for professional services; reasonable efforts were made to collect these billed charges and a majority of all patients actually paid the charges in

whole or in substantial part. The hospital would have to provide evidence that it meets these tests for fee-for-service reimbursement before the payments could be made.

A hospital eligible for fee-for-service reimbursement on the basis of the requirement described in the above exception could, if it chose, elect to be reimbursed on the cost basis provided for by the bill if the election would be advantageous to the program in that it might reduce billing difficulties and costs. Similarly, where it would be advantageous to the program and would not be expected to increase the program's liability, the cost reimbursement provisions of the bill could serve as the basis for payment for teaching physicians' services furnished in the past where procedural difficulties have prevented a determination of the amount of fee-for-service that is appropriate.

The committee expects that in any borderline or questionable areas concerning whether reimbursement for the services of teaching physicians in a given institution or setting should be on a costs or charges basis, reimbursement would be on the basis of costs.

Where States elect to compensate for services of teaching or supervisory physicians under medicaid, Federal matching should be limited to reimbursement not in excess of that allowable under medicare.

An important effect of these various coverage and co-pay provisions would be that, where the cost-reimbursement approach is applicable, reimbursement for the physician's teaching activities and his related patient care activities would always be provided under the same provisions of the law. This would greatly simplify the administration of the program by making it unnecessary to distinguish, as required by present law, between a physician's teaching activities and patient care activities in submitting and paying bills.

Another provision in this section would permit a hospital to include among its reimbursable costs the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered as inpatient hospital services or outpatient hospital services. In order to receive reimbursement the hospital would be required to pay the reasonable cost of such services to medicare patients to the institution that bore the cost. The committee expects that such costs will be reimbursable only where there is a written agreement between the hospital and medical school specifying the types and extent of services to be furnished by the school and disposition of any reimbursement received by the hospital for those services.

This amendment would be effective with respect to accounting periods beginning after December 31, 1972.

Advance Approval of Extended Care and Home Health Coverage Under Medicare

(Sec. 228 of the bill)

Under present law, extended care benefits are payable only on behalf of patients who, following a hospital stay of at least 3 consecutive days, require skilled nursing care on a continuing basis for further treatment of the condition which required hospitalization. The posthospital home health benefit is payable on behalf of patients

who, following hospitalization or an extended care facility stay, continue to require essentially the same type of nursing care on an intermittent basis, or physical or speech therapy. However, extended care facilities and home health agencies often care for patients who need less skilled and less medically oriented services in addition to patients requiring the level of care which is covered by the program.

Under current law, a determination of whether a patient requires the level of care that is necessary to qualify for posthospital extended care or home health benefits cannot generally be made until some time after the services have been furnished. The committee is aware that in many cases such benefits are being denied retroactively and that another provision in the committee bill, which would revise the definition of extended care to permit coverage of additional types of skilled care, would not eliminate the probability that such retroactive denials will continue. The harsh result is that the patient is faced with a large bill he expected would be paid or the facility or agency is faced with a patient who may not be able to pay his bill. The uncertainty about eligibility for these benefits that exists until after the care has been given tends to encourage physicians to either delay discharge from the hospital, where coverage may less likely be questioned, or to recommend a less desirable, though financially predictable, course of treatment. The aggregate effect is to reduce the value of the posthospital extended care and home health benefits as a continuation of hospital care in a less intensive—and less expensive—setting as soon as it is medically feasible for the patient to be moved.

The committee believes that to the extent that valid criteria can be established posthospital extended care and home health benefits should be more positively identified by type of medical condition which ordinarily requires such care and that minimum coverage periods should be assured for such conditions. To achieve this purpose the committee has concurred with a provision in the House bill which would authorize the Secretary to establish, by medical conditions and length of stay or number of visits, periods for which a patient would be presumed to be eligible for benefits. The Secretary would undertake such activities to the extent that a Professional Standards Review Organization was not exercising comparable responsibility in an area. These periods of presumed coverage would be limited to those conditions which program experience indicates are most appropriate for the extended care or home health level of services following hospitalization, taking into account such factors as length of hospital stay, degree of incapacity, medical history and other health factors affecting the type of services to be provided.

The committee recognizes that, in order to avoid the risk of presuming coverage (by general medical category) in substantial numbers of cases where extended care or home health care may not be required, presumed coverage periods must necessarily be limited in duration and will not, in many cases, encompass the entire period for which the patient will require covered care. Nevertheless, these minimum presumed periods will provide a dual advantage over the present system of coverage determination by (1) encouraging prompt transfer through assurance that the admission or start of care will be reimbursed and (2) identifying in advance the point at which further assessment should be made, on an individual case basis, of continuing need for

extended or home health care. Where request for coverage beyond the initial presumed period, accompanied by appropriate supporting evidence, is submitted for timely advance consideration, it is expected that a decision to terminate extended care or home health coverage would ordinarily be effected on a prospective basis. For those conditions for which specific presumed periods cannot be established, current procedures for determining coverage would continue to apply. However, the Professional Standards Review Organization, which would be established under section 249F of the committee's bill (or the fiscal intermediary where no PSRO is performing such functions) should be able to make appropriate reviews on a timely basis for such admissions.

To prevent abuse of the advance approval procedure the PSRO or intermediary (in the absence of a PSRO) and facilities would be expected to monitor, through periodic review of a sample of paid stays, utilization review committee studies, and similar measures, the reliability of individual physicians in describing the patients' conditions or certifying patients' needs for posthospital extended care and home health services. The Secretary could suspend the applicability of the advance approval procedure for patients certified by physicians who are found to be unreliable in this respect.

This provision would be effective January 1, 1973.

Authority of Secretary To Terminate Payments to Suppliers of Services

(Sec. 229 of the bill)

Present law does not authorize the Secretary to withhold future payments for services furnished by an institutional provider of services, a physician, or any other supplier who either abuses the program or endangers the health of beneficiaries, although payment for past or current claims may be withheld on an individual basis where the services are not reasonable or necessary for treatment of illness or injury or where the supplier fails to provide the necessary payment information.

The committee believes it important to protect the medicare, medicaid, and maternal and child health programs and their beneficiaries from those suppliers of services who have made a practice of furnishing inferior or harmful supplies or services, engaging in fraudulent activities, or consistently overcharging for their services. Such protection is not now provided under the law. For example, if a physician is found guilty of fraud in connection with the furnishing of services to a medicare beneficiary, there is no authority under present law to bar payment on his subsequent claims so long as the physician remains legally authorized to practice. States can, and some do, bar from medicaid providers who abuse the program, but they are not now required to do so.

The committee approves the House provision, previously included in H.R. 17550, under which the Secretary would be given authority to terminate or suspend payments under the medicare program for services rendered by any supplier of health and medical services found to be guilty of program abuses. The Secretary would make the names

of such persons or organizations public so that beneficiaries would be informed about which suppliers cannot participate in the program and for whose services payment will not be made. The situations for which termination of payment could be made include overcharging, furnishing excessive, inferior, or harmful services, or making a false statement to obtain payment. Also, there would be no Federal financial participation in any expenditure under the medicaid and maternal and child health programs by the State with respect to services furnished by a supplier to whom the Secretary would not make medicare payments under this provision of the bill.

Program review teams would be established in each State by the Secretary, following consultation with groups representing consumers of health services, State and local professional societies, and the appropriate intermediaries and carriers utilized in the administration of title XVIII benefits. Both the professional and the nonprofessional members of the program review teams would be responsible for reviewing and reporting on statistical data on program utilization (which the Secretary would periodically provide). Only the professional members of the program review teams would review cases involving the furnishing of excessive, inferior, or harmful services in order to assure that only professionals will review other professionals under this provision. The committee notes that a Professional Standards Review Organization (PSRO), to be established under another provision of the committee bill, would generally have the personnel and expertise to perform this function and, therefore, expects the Secretary to utilize the services of a PSRO whenever feasible in lieu of a separate program review team, as PSRO's become operative.

It is not expected that any large number of suppliers of health services will be suspended because of abuse. However, the existence of the authority and its use in even a relatively few cases is expected to provide a substantial deterrent.

Any person or organization dissatisfied with the Secretary's decision to terminate payments would be entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision.

It is not intended that this provision would in any way change the Secretary's present right to withhold payment where necessary payment information is not provided. Nor would the supplier of services be entitled to a hearing or judicial review with respect to payments withheld under such existing authority.

The provisions relating to title XVIII would be effective with respect to determinations made by the Secretary after enactment of the bill. The provisions relating to titles V and XIX would be effective with respect to items or services furnished on or after December 31, 1972.

Elimination of Requirement That States Move Toward Comprehensive Medicaid Programs

(Sec. 230 of the bill)

Section 1903(e) of the medicaid statute requires that each State make "a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under

the plan and in the direction of liberalizing the eligibility requirements for medical assistance." Under an amendment adopted by the Congress in 1969 (Public Law 91–36), the operation of this provision was suspended for two years, until July 1, 1971, and the date by which the States were to have comprehensive medicaid programs (applying to everyone who meets their eligibility standards with respect to income and resources) was changed from 1975 to 1977.

The committee has been concerned with the burden of the medicaid program on State finances. The expansion of the medicaid program and liberalization of eligibility requirements for medical assistance which is required by section 1903(e) could increase this burden and may result in States either cutting back on other programs or their considering dropping medicaid.

The committee agrees with the action of the House repealing section 1903(e). When the operations of the State medicaid programs have been substantially improved and there is assurance that program extensions will not merely result in other medical costs inflation, the question of expansion of the program can then be reconsidered.

Amount of Payments Where Customary Charges for Services Furnished Are Less Than Reasonable Cost

(Sec. 233 of the bill)

Under present law, reimbursement under the medicare program is based on the reasonable costs incurred by providers of services (but only for inpatient hospital services under medicaid and the maternal and child health programs) in providing services to individuals covered by these programs. This results, in some cases, in these programs paying higher amounts for services received by covered individuals than such individuals would be charged if they were not covered by these programs, because, in some cases, a provider's customary charges to the general public are set at a level which does not reflect the provider's full costs.

The committee believes that it is inequitable for the medicare, medicaid, and the child health programs to pay more for services than the provider charges to the general public. To the extent that a provider's costs are not reflected in charges to the public generally, such costs are expected to be met from income other than revenues from patient care—for example, from endowment or investment income. The bill would provide, therefore, that reimbursement for services under the medicare, medicaid, and maternal and child health programs could not exceed the lesser of the reasonable cost of such services as determined under section 1861(v) of the Social Security Act, or the customary charges to the general public for such services.

However, the committee believes that it would be undesirable to apply this provision in the case of services furnished by public providers of services free of charge or at a nominal fee. The bill would provide, therefore, that where services are furnished by a public provider of services free of charge or at a nominal charge, the Secretary shall specify by regulation reimbursement based on those elements of

costs generally allowed in the determination of reasonable cost that he finds will result in fair reimbursement for such services. In such cases fair reimbursement for a service could not exceed, but could be less than the amount that would be paid under present law.

The committee recognizes that a provider's charges may be lower than its costs in a given period as a result of miscalculation or special circumstances of limited duration, and it is not intended that providers should be penalized by such short-range discrepancies between costs and charges. Nor does the committee want to introduce any incentive for providers to set charges for the general public at a level substantially higher than estimated costs merely to avoid being penalized by this provision. Thus, the committee recognizes the desirability of permitting a provider that was reimbursed under the medicare, medicaid and child health programs on the basis of charges in a fiscal period to carry unreimbursed allowable costs for that period forward for perhaps two succeeding fiscal periods. Should charges exceed costs in such succeeding fiscal periods, the unreimbursed allowable costs carried forward could be reimbursed to the provider along with current allowable costs up to the limit of current charges.

The committee intends that for purposes of administering this provision, "customary charges" shall mean (1) the charges listed in an established charge schedule (if the institution has only a single set of charges applied to all patients), or (2) the most frequent or typical charges imposed (if the institution uses more than one charge for a single service). However, in order to be considered to be the "customary charge," a charge would have to be one that was actually collected from a substantial number of individuals. A charge set up in name only, perhaps primarily to avoid the effect of this provision, is not intended to determine medicare reimbursement.

The provisions relating to medicare would be effective with respect to services furnished by hospitals, skilled nursing facilities and home health agencies in accounting periods beginning after December 31, 1972. Provisions relating to medicaid and maternal and child health would be effective for accounting periods beginning after December 31, 1972.

Institutional Planning Under Medicare

(Sec. 234 of the bill)

Under present medicare law, there is no requirement for providers of services to develop fiscal plans such as operating and capital budgets. However, the committee is aware of the fact that health care facilities have come under increasing criticism on the grounds that they fail to follow sound business practices in their operations. The Advisory Committee on Hospital Effectiveness, established by the Secretary of HEW in its report stated, "* * * the fact must be faced that deficiencies in hospital management owe something, at least to inattention, indifference, or lack of information on the part of some hospital boards, and some trustees with the best intentions and energy have not been adequately informed by administrations on what the functions of a hospital trustee, or a hospital should be." In recommending

84-378 O - 72 - 3

the requirement contained in the bill, the Secretary's committee stated, "The requirement that detailed budgets and operating plans be prepared annually as a condition of approval for participation in Federal programs can be expected to disclose management inefficiencies in such health care institutions as a necessary first step toward bringing about needed improvements. Especially, the committee believes this requirement will compel the attention of many hospital trustees to lapses in management that would not be permitted in their own businesses."

The Committee on Finance agrees with the provision in the House bill which would require providers of services (including hospitals accredited by the Joint Commission on Accreditation of Hospitals), as a condition of participation under the medicare program, to have a written overall plan and budget reflecting an operating budget and a capital expenditures plan. The overall plan would be expected to contain information outlining the services to be provided in the future, the estimated costs of providing such services (including proposed capital expenditures in excess of $100,000 for acquisition of land, buildings, and equipment and replacement, modernization, and expansion of the buildings and equipment), and the proposed methods of financing such costs. It would have to be prepared under the direction of the governing body of the institution, by a committee consisting of representatives of that body, the administrative staff and the medical staff. The plan would cover the immediately following year and the immediately following 3-year accounting period and would be reviewed and updated annually to assure that it is consistent with the budgetary program of the provider.

The plan would not be reviewed for substance by the Government or any of its agents. The purpose of the provision is to assure that such institutions carry on budgeting and planning on their own. It is not intended that the Government will play any role in that process.

A similar provision was approved by the committee in 1970 and included in H.R. 17550 as passed by the Senate.

The new condition of participation would have to be met with respect to any provider of services for fiscal years of the provider beginning after the fifth month after the month of enactment.

Prohibition Against Reassignment of Claims to Benefits

(Sec. 236 of the bill)

Under present law, payment for services furnished by a physician or other person under the supplementary medical insurance program is made: (1) to the beneficiary on the basis of an itemized bill, or (2) to the physician or other person who provided the services on the basis of an assignment under the terms of which the reasonable charge is the full charge for the service. Present law also provides that payment for such services under the medicaid program is made to the physician or other person providing the services. The law is silent with respect to reassignment by physicians or others who provide services of their right to receive payment under these programs. The Department of Health,

Education, and Welfare makes such reassigned payments under medicare without specific legislative authority.

Experience with this practice under these programs shows that some physicians and other persons providing services reassign their rights to other organizations or groups under conditions whereby the organization or group submits claims and receives payment in its own name. Such reassignments have been a source of incorrect and inflated claims for services and have created administrative problems with respect to determinations of reasonable charges and recovery of overpayments. Fraudulent operations of collection agencies have been identified in medicaid. Substantial overpayments to many such organizations have been identified in the medicare program, one involving over a million dollars.

The committee concurs with a provision in the House bill which seeks to overcome these difficulties by prohibiting payment under these programs to anyone other than the patient, his physician, or other person who provided the service, unless the physician or other person is required as a condition of his employment to turn his fees over to his employer, or unless the physician or other person has an arrangement with the facility in which the services were provided under which the facility bills for the services. Also, direct payment could be allowed to a foundation, association, plan, or contractor which provides and administers health care through an organized health care delivery system. An example of this type of organization would be a prepaid group practice or other system recognized by the State title XIX agency. It is not the intent of the committee that this provision apply to payments to providers of services that are based on the reasonable cost of the services.

This provision would not preclude a physician or other person who provided the services and accepted an assignment from having the payment mailed to anyone or any organization he wishes, but the payment would be to him in his name.

The provision would in no way interfere with the fiscal relationships between physician and hospitals, in the case of hospital-based pathologists and radiologists, for example.

This provision as it applies to medicare would be effective with respect to bills submitted after the enactment date. For medicaid the provision would be effective January 1, 1973, or earlier if the State plan so provides.

Notification of Unnecessary Admission to a Hospital or Extended Care Facility Under Medicare

(Sec. 238 of the bill)

Under present law, the utilization review committee required to function in each hospital and extended care facility must review all long-stay cases and at least a sample of admissions. When in the review of a long-stay case the utilization review committee determines that further stay in the institution is not medically necessary, the committee is required to notify promptly the physician, the patient, and

the institution of its finding. No medicare payment is made for any services furnished after the third day following such notification.

The committee approves the provisions in the House bill which would require a similar notification, and a similar payment cut-off after 3 days, to be made where the utilization review committee in its sample or other review of admissions finds a case where hospitalization or extended care is no longer necessary (or never was necessary). Thus, the committee's bill would remove the anomaly of continuing payment in a case where the utilization review committee determined in the course of sample or other review that admission to the institution or further stay was not necessary and would make parallel the treatment accorded long-stay cases and cases reviewed on a sample basis.

This provision would be effective with respect to services furnished after the second month following enactment of the bill.

Use of State Health or Other Appropriate Medical Agency To Perform Certain Functions Under Medicaid and Maternal and Child Health Programs

(Sec. 239 of the bill)

Under present law, one State agency may have the responsibility for certifying health facilities for participation in the medicare program and another agency for certifying health facilities for participation in medicaid and maternal and child health programs. The committee believes that this duplication of effort in the verification of and in the establishment and maintenance of health standards is unnecessary and inefficient. The committee's bill would require the State to provide that the State health agency (or the State medical agency which licenses health facilities) shall perform these functions for medicare, medicaid, and the maternal and child health programs.

In its approval of a similar provision in H.R. 17550, the committee authorized the use of the appropriate State agency rather than limiting the designation to "State health agency," since in some States another agency performs the certification function for medicare. The House has incorporated this change into this section in H.R. 1.

The committee also believes that the effectiveness and economy of the medicaid program would be enhanced through development of capability in each State to perform utilization reviews, to establish standards relating to the quality of health care furnished to medicaid recipients, and to review the quality of the services provided. Activities such as these would provide information on the under- or over-utilization of resources and the quality and appropriateness of care. These activities would be undertaken only where they are not duplicative of responsibilities assumed by professional standards review organizations.

To encourage the development of the capabilities upon which these improvements would be based, the committee bill provides for the establishment of standards relating to the quality of care furnished

to medicaid recipients, and review by appropriate professional health personnel of the quality and appropriateness of services provided. Federal matching at the 75-percent rate is now available for the costs of the health professionals and their supporting staff found necessary in carrying out such functions.

This provision would be effective January 1, 1973.

Relationship Between Medicaid and Comprehensive Health Care Programs

(Sec. 240 of the bill)

Present law provides that under medicaid all eligible recipients should receive the same scope of services; that those services should be available throughout the State and that recipients should have freedom of choice with regard to where they receive their care.

Section 1902(a)(23) also provides that recipients be allowed to obtain medical care through organizations which provide such services (or arrange for their availability) on a prepayment basis, if the recipient so chooses.

State agencies often cannot make pre-payment arrangements with organizations such as neighborhood health centers or prepaid group practices to provide services to medicaid recipients which might result in more efficient and economical delivery of health services, because the prospective arrangements might violate the law in that some recipients might receive a broader scope of benefits than others. This is so because the possibility for making such arrangements may only exist in certain areas of a State. In addition, these organizations provide services which are often broader in scope than the services received under the medicaid plan, and, therefore, are not available throughout the State. Under current law States are able to contract with such organizations only; (a) through a waiver provision because the particular contract is a demonstration project, or (b) through establishing a separate premium rate for the particular set of services offered under the State plan.

The committee added an amendment to H.R. 17550 designed to meet this problem by allowing States to waive Federal statewideness and comparability requirements when arranging for the delivery of health services on a prepaid basis. The House has incorporated this provision into H.R. 1.

The committee reaffirms its earlier position in approving the House provision which would enable States to waive Federal statewideness and comparability requirements, if a State contracts with an organization which has agreed to provide health care and services in addition to those offered under the State plan to eligible people who reside in the geographic area served by such an organization, and who elect to obtain such care and services from such an organization. Payments to such organizations could not be higher on a per capita basis than per capita payments expended for medicaid eligibles in the same general geographic area who are not under the proposed arrangement.

Penalties for Fraudulent Acts and False Reporting Under Medicare and Medicaid

(Sec. 242 of the bill)

Under present law, a false statement or representation of a material fact in any application for payment under social security programs is defined as a misdemeanor and carries a penalty of up to 1 year of imprisonment, a fine of $1,000, or both.

The committee believes that a specific provision defining acts subject to penalty under the medicare and medicaid programs should be included to provide penalties for certain practices which have long been regarded by professional organizations as unethical, as well as unlawful in some jurisdictions, and which contribute appreciably to the cost of the medicare and medicaid programs. Thus, under a provision in the House bill approved by the committee with technical changes, the criminal penalty provision would include such practices as the soliciting, offering, or accepting of kickbacks or bribes, including the rebating of a portion of a fee or charge for a patient referral, involving individuals, providers of health care services and business entities such as corporations, companies, associations, firms, partnerships, societies, and joint stock companies. In addition, the provision would include penalties for concealing or failing to disclose knowledge of any event affecting a person's right to any benefit payment with the intent to defraud, or for knowingly and willfully converting benefits or payments to improper use. The penalty for such acts, as well as false statements or representations of material facts in any application for payment under the medicare and medicaid programs, would be a fine of $10,000, 1 year of imprisonment, or both.

Continuing investigation and review of reports by the General Accounting Office have indicated that false statements may have been made by individuals and institutions with respect to health and safety conditions and operating conditions in health care facilities in order to secure approval for participation in the medicare and medicaid programs. While the numbers of different individuals and institutions involved in such fraud may not be large in relation to the number participating in the program, the committee believes that a specific penalty for such acts should be provided to deter the making or inducing of such statements. Thus, specific provisions would be included under title XVIII (medicare) and under title XIX (medicaid) of the Social Security Act whereby anyone (including, but not limited to, such business entities as corporations, companies, associations, firms, partnerships, societies, and joint stock companies) who knowingly and willfully makes, or induces or seeks to induce the making of, a false statement of material fact with respect to the conditions and operation of a health care facility or agency in order to secure certification or recertification or approval to participate in the medicare and medicaid programs would be subject to imprisonment for up to 6 months, a fine not to exceed $2,000, or both.

These provisions would be in addition to and not in lieu of any other penalty provisions in State or Federal law. A similar provision was approved by the committee in 1970 and included in H.R. 17550 as passed by the Senate.

Coverage of Supplies Related to Colostomies

(Sec. 252 of the bill)

Medicare covers the bag and straps which must be used in conjunction with some colostomies (an artificial opening of the bowel to the abdominal wall which is often made necessary by surgery for cancer of the bowel). The equipment is covered as it is considered a prosthetic device (a replacement for a body organ).

Some bowel cancer patients have surgery which results in a different type of colostomy necessitating daily irrigation and flushing rather than permanent attachment of a bag. Medicare does not cover this irrigation and flushing equipment, since it is not permanently attached to the body and is therefore not considered a prosthetic device. This results in unequal treatment by the program of patients with colostomies.

The committee bill would add a phrase to the statute to include coverage for material directly related to the care of a colostomy.

The amendment is effective upon enactment.

Coverage Prior to Application for Medicaid

(Sec. 255 of the bill)

Under present law a State may, at its own option, cover the cost of health care provided to an otherwise qualified recipient for the three months prior to his application for medicaid. Thirty-one States have elected to provide this coverage, thereby protecting persons who are eligible for medicaid but do not apply for assistance until after they have received care, either because they did not know about the medicaid eligibility requirements or because the sudden nature of their illness prevented their applying.

The committee agrees with the House that such coverage is reasonable and desirable and recommends, as it did in 1970 in H.R. 17550, that States be required to provide protection for that 3-month period. Therefore, the committee bill requires all States to provide coverage for care and services furnished in or after the third month prior to application to those individuals who were otherwise eligible when the services were received. Included as eligible under the three-months retroactive coverage requirement would be deceased individuals whose fatal condition prevented them from applying for medicaid coverage but who would have been eligible if application had been made.

States are expected to modify their provider agreements where applicable so as to permit the application of appropriate utilization control procedures retroactively in these cases to assure that appropriate and necessary care was delivered.

This provision would be effective July 1, 1973.

Hospital Admissions for Dental Services Under Medicare

(Sec. 256 of the bill)

Under present medicare procedures, when a patient is hospitalized in connection with the performance of noncovered dental procedures, payment may be made for inpatient hospital services if the patient has other impairments so severe that hospitalization is necessary. In

some cases, intermediaries require that a physician certify to the medical necessity of dental admissions, since hospitalization is ordinarily not necessary for the provision of dental services. Where such a certification is required, the dentist who will be performing the dental procedures must arrange for a physician to make the necessary certification.

The committee approves the provision in the House bill which would authorize the dentist who is caring for the patient to make the certification of the necessity for inpatient hospital admission for noncovered dental services under the above circumstances without requiring a corroborating certification by a physician. The committee believes that in these kinds of cases the dentist is in a better position to make the necessary evaluation of the patient's condition and probable reaction to dental surgery than is a physician who may not be familiar either with the patient or the nature of the dental procedures to be performed.

This provision would be effective with respect to admissions occurring after the second month following enactment of the bill.

Extension of Grace Period for Termination of Supplementary Medical Insurance Coverage Where Failure To Pay Premiums Is Due to Good Cause

(Sec. 257 of the bill)

Under present law, an individual's coverage under the supplementary medical insurance part of medicare is terminated for nonpayment of premiums. The termination is effective on a date determined under regulations which may be established so as to provide a grace period (not in excess of 90 days) during which overdue premiums may be paid and coverage continued.

Several types of cases have arisen in which termination of an individual's supplementary medical insurance protection for failure to pay all premiums due within 90 days is clearly inequitable. For example, there have been cases where for reasons of physical or mental incapacity the enrollee was unable to make the premium payment within the allowed time limit and there was no one acting on his behalf to protect his interests. In other cases, coverage has been terminated because the enrollee mistakenly believed that payment had been made when actually it had not.

The committee approves the provision in the House bill which would extend the 90-day grace period for an additional 90 days where the Secretary finds that there was good cause for failure to pay the premium before the expiration of the initial 90-day grace period.

This provision would apply to such cases of nonpayment of premiums due within the 90-day period preceding the date of enactment.

Extension of Time for Filing Claim for Supplementary Medical Insurance Benefits Where Delay Is Due to Administrative Error

(Sec. 258 of the bill)

Under present law, a claim for benefits under the supplementary medical insurance program must be filed by December 31 of the year following the year in which the services were provided. (For this pur-

pose, services furnished in the last 3 months of a year are deemed to have been furnished in the following year.) The present time limit is adequate for the vast majority of supplementary medical insurance claims. In some few cases, however, beneficiaries have failed to file a timely claim due to a mistake or other action on the part of the Government or one of its agents. For example, misinformation from an official source or delay in establishing supplementary medical insurance entitlement has resulted in late filing of claims.

The committee has approved a provision in the House bill which would provide that where a claim under supplementary medical insurance is not filed timely due to error of the Government or one of its agents, the claim may nevertheless be honored if filed as soon as possible after the facts in the case have been established. This provision would assure that claimants would not be treated inequitably because of such an error.

This amendment would apply with respect to bills submitted and requests for payment made after March 1968.

Waiver of Enrollment Period Requirements Where Individual's Rights Were Prejudiced by Administrative Error or Inaction

(Sec. 259 of the bill)

Under present law, an individual can enroll in the supplementary medical insurance program during his initial 7-month enrollment period, beginning with the third month before the month he attains age 65, or during any general enrollment period (during the first 3 months of each year), which begins within 3 years after the end of his initial enrollment period. (The committee bill includes a provision which would eliminate the 3-year limit on enrollment. That provision is discussed immediately following discussion of this provision.)

There have been some relatively rare cases in which it has been discovered that due to an action, inaction, or error on the part of the Government an individual is in fact enrolled, or is in fact not enrolled, under suppementary medical insurance when both the individual and the Government had until then believed that the reverse was true. Although rare, such cases may be a cause of considerable hardship and distress to the individuals involved, and present law permits no relief to be given.

The committee shares the belief of the Committee on Ways and Means that where an individual's enrollment rights under supplementary medical insurance has been prejudiced because of the action, inaction or error on the part of the Government, he should not be penalized or caused hardship. The bill, therefore, authorizes the Secretary to provide such equitable relief as may be necessary to correct or eliminate the effects of these situations, including (but not limited to) the establishment of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums.

This provision would apply to all cases which have arisen since the beginning of the program but it is not contemplated that the administration be required to conduct an extensive search for cases which arose prior to enactment.

Elimination of Provisions Preventing Enrollment in Supplementary Medical Insurance Program More Than 3 Years After First Opportunity

(Sec. 260 of the bill)

Under present law, an individual can enroll for the first time in the supplementary medical insurance program during his initial 7-month enrollment period, beginning with the third month before the month he attains age 65, or during any general enrollment period (during the first 3 months of each year) which begins within 3 years after the end of his initial enrollment period. A person whose enrollment has terminated may not enroll for the second time in supplementary medical insurance unless he does so in a general enrollment period which begins within 3 years after the effective date of such termination. An individual may reenroll only once.

The 3-year enrollment limit was included in the law (as are other limitations on enrollment in the supplementary medical insurance program) in the interest of avoiding antiselection in case the enrollment under the program was not a very substantial proportion of people eligible to enroll. For example, substantial numbers of people who are relatively healthy might delay enrollment until they are well past age 65 and have become sick, at which point they would enroll and receive substantial benefits without having paid much in premiums. However, since there is now a 95-percent rate of participation in the program and since the vast majority of enrollees enroll at the earliest possible time, there would seem to be no reason to retain the 3-year limit on enrollment. Further, present law provides that premiums for late enrollees are increased 10 percent for each full 12 months elapsed between the time they could have enrolled and actually do enroll and this provision would be retained. Such late-enrollment charges serve to prevent antiselection and to meet the higher costs associated with those who enroll at older ages. It is not intended, of course, that the months for which the law itself precluded individuals from enrolling or reenrolling would apply in determining the late-enrollment charges.

The committee approves the provision in the House bill which would eliminate the 3-year limit with respect to both initial enrollment and reenrollment after an initial termination. Enrollment periods would remain as presently defined and the restriction limiting individuals who terminate enrollment to reenroll only once would be retained.

This provision would apply to all those who are ineligible to enroll because of the 3-year limit in effect under present law.

Waiver of Recovery of Incorrect Medicare Payments From Survivor Who Is Without Fault

(Sec. 261 of the bill)

Under present law, an individual to whom (or on behalf of whom) a medicare overpayment is made is subjected to recovery action with respect to such overpayment, except that the recovery action may be waived if the individual is without fault and if recovery would de-

feat the purposes of the cash social security title (title II) of the Social Security Act or would be against equity and good conscience. If such individual dies, recovery action is initiated as necessary from any other individual who is receiving cash social security benefits on the same earnings record as the deceased overpaid beneficiary. In the latter situation, however, waiver of recovery action is not permitted even though the surviving beneficiary—a widow, for example—is without fault with respect to the overpayment.

The Social Security Amendments of 1967 included a provision which permitted recovery to be waived in the case of cash benefits if the individual from whom recovery is being considered is without fault, even though the overpaid individual was at fault. However, the comparable change with respect to medicare overpayments was not made. As a result, there are situations in which, for example, an overpayment made to a deceased beneficiary is the responsibility of his widow even though she was without fault in causing the overpayment, whereas if the overpayment had been made to or on behalf of the widow herself, the waiver provision would apply if she were not at fault.

The committee approved a provision in the House bill which would rectify this anomaly by permitting any individual who is liable for repayment of a medicare overpayment to qualify for waiver of recovery of the overpaid amount if he is without fault and if such recovery would defeat the purposes of title II or would be against equity and good conscience.

Requirement of Minimum Amount of Claim To Establish Entitlement to Hearing Under Supplementary Medical Insurance Program

(Sec. 262 of the bill)

Under present law, people enrolled in the supplementary medical insurance program are assured an opportunity for a fair hearing by the carrier when requests for payment under supplementary medical insurance are denied or are not acted upon with reasonable promptness, or when the amount of the payment is in controversy, regardless of the dollar amount at issue. Experience under the program indicates that the holding of a full fair hearing is unwarranted in cases where the amount in controversy is relatively small. Carriers have reported cases involving $5 and $10 claims for which the cost of holding a fair hearing has exceeded $100. Approximately 45 percent of the hearings held since the beginning of the program have involved an amount less than $100. Further, regulations require carriers to have a reconsideration review of all denied claims. Such review involves different claims personnel than those who acted on the original claim and should be sufficient protection in small claims cases.

The committee approved a provision of the House bill which would require that a minimum amount of $100 be at issue before an enrollee in the supplementary medical insurance program will be granted a fair hearing by the carrier.

The provision would be effective with respect to hearings requested after the enactment of the bill.

Provide That Services of Optometrists in Furnishing Prosthetic Lenses Not Require a Physician's Order

(Sec. 264 of the bill)

Under present law, optometric services are not covered except with respect to services incidental to the fitting and supplying of prosthetic lenses ordered by a physician. The House bill does not provide for any change in the present limitation on coverage of optometric services.

The committee believes that the medicare requirement that a physician's prescription or order accompany requests for payment for covered prosthetic lenses when such lenses are furnished by an optometrist unduly limits both patient and optometrist. The patient's choice of having either an ophthalmologist or an optometrist to furnish him with prosthetic lenses should no longer be biased by this requirement.

The committee therefore agrees with the provision in the House bill which would recognize the ability of an optometrist to attest to a beneficiary's need for prosthetic lenses by amending the definition of the term "physician" in title XVIII to include a doctor of optometry authorized to practice optometry by the State in which he furnishes services. An optometrist would be recognized as a "physician" only for the purpose of attesting to the patient's need for prosthetic lenses. (Of course, neither the physician nor the optometrist would be paid by medicare for refractive services when the beneficiary has been given a prescription by a physician for the necessary prosthetic lenses.) This change would not provide for coverage of services performed by optometrists other than those covered under present law, nor would it permit an optometrist to serve as a "physician" on a professional standards review organization.

A similar provision was developed by the committee in 1970 and included in H.R. 17550 as passed by the Senate.

Refund of Excess Premiums Under Medicare

(Sec. 266 of the bill)

Under present law, where part B entitlement terminates due to the death of the enrollee, refund of any excess premiums is made, upon claim, to the legal representative of the enrollee's estate. If there is no legal representative and it is reasonably certain that none will be appointed, refund may be made, only upon claim, to a relative of the deceased on behalf of the estate.

Early in the program it was recognized that excess part B premiums paid by a deceased enrollee could be best disposed of, in those cases where there is no legal representative of the deceased's estate, by adding them to benefits subsequently payable on the same medicare claims number or to those relatives who would (except for age or dependency requirements) be eligible on the same record. However, the Office of General Counsel advised that this could not be done in the absence of necessary authority in the law. Consequently, the much more cumbersome claims procedure has had to be used. Where there is no claim for the excess premium payments, no refund is made.

A similar problem is likely to exist with respect to premiums paid in advance under those provisions of the bill which would provide, at an initial cost of $33 per month per enrollee, hospital insurance coverage for people who are age 65 and over who are not eligible for such coverage under present law and certain other persons age 60 to 64.

The committee has therefore approved a provision in the House bill which would provide authority for the Secretary to dispose of excess supplementary medical insurance premiums and excess hospital insurance premiums in the same manner as unpaid medical insurance benefits are treated.

A similar provision was approved by the committee in 1970 and included in H.R. 17550 as passed by the Senate.

Exemption of Christian Science Sanatoriums From Certain Nursing Home Requirements Under Medicaid

(Sec. 268 of the bill)

Under present law, Christian Science sanatoriums are permitted to participate in the medicaid program as skilled nursing homes, and as such, are required to meet the general requirements established for skilled nursing homes.

The committee agrees with the House that Christian Science sanatoriums which do not actually provide medical care, should not be required to have a skilled nursing home administrator licensed by the State, to maintain an organized nursing service under the direction of a registered nurse, to maintain detailed medical records, or to have diagnostic and other service arrangements with general hospitals. The bill would, therefore, exempt Christian Science sanatoriums from the requirements for a licensed nursing home administrator, requirements for medical review, and other inappropriate requirements of the medicaid program.

Such sanatoriums will be expected to continue to meet all applicable safety standards.

The committee approved a similar amendment in 1970.

Increase in Maximum Federal Medicaid Amount for Puerto Rico

(Sec. 271 of the bill)

At present, Federal matching funds for Puerto Rico's medicaid expenditures are at a rate of 50 percent, except that the total amount of Federal funds may not exceed $20 million in any fiscal year.

The committee believes that the $20 million Federal maximum on medicaid payments to Puerto Rico should be adjusted to reflect the rise in hospital and health care costs, as well as the increase in the number of persons eligible for medicaid since 1967, when the ceiling and matching rates were established.

The committee recognizes the efforts made by Puerto Rico to provide comprehensive health care. Among the jurisdictions with medicaid programs, Puerto Rico ranks 13th in expenditures per inhabitant

for medical assistance. Because Puerto Rico spends considerably more on its medicaid program than the $20 million necessary to receive full Federal matching, the Federal share of Puerto Rico's title XIX program was only about 39 percent in fiscal year 1971.

The committee therefore added a provision to H.R. 17550 providing that the Federal ceiling on title XIX payments to Puerto Rico be increased to $30 million effective with fiscal year 1972 and fiscal years thereafter. The 50 percent Federal matching rate would remain unchanged.

The House indicated their approval of the committee action in 1970 by including a similar provision in H.R. 1.

Inclusion of American Samoa and the Trust Territory of the Pacific Islands Under Title V

(Sec. 272 of the bill)

American Samoa and the Trust Territory of the Pacific Islands are not presently eligible to receive formula fund allocations under the maternal and child health and crippled children programs, as are States and Puerto Rico and the Virgin Islands.

In order to improve maternal and child health and crippled children programs in these areas, the Finance Committee has approved an amendment to authorize eligibility under title V for Samoa and the Trust Territory of the Pacific Islands.

The resulting cost is estimated to be approximately $35,000 per year.

2. PROVISIONS OF THE HOUSE BILL SUBSTANTIALLY MODIFIED BY THE COMMITTEE

Change in Hospital Insurance Coinsurance for Lifetime Reserve Days Under Medicare

(Sec. 205 of the bill)

Under present law, payment may be made for up to 90 days of inpatient hospital services furnished during a benefit period (spell of illness), with the beneficiary being responsible for an inpatient hospital deductible (currently $68) and, beginning with the 61st day of his stay, a daily coinsurance amount equal to one-fourth of the inpatient hospital deductible (now $17). In addition, present law provides each beneficiary with a nonrenewable lifetime reserve of 60 days of inpatient hospital coverage upon which he may draw after having exhausted the 90 days of covered care regularly available to him in a benefit period; a coinsurance amount equal to one-half of the inpatient hospital deductible is applicable to each lifetime reserve day used.

The House bill would provide for the application of a daily coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day of inpatient hospital coverage during a benefit period beginning with the 31st day and through the 60th day. The House bill also would provide for an increase from 60 to 120 in the number of "lifetime reserve" days for which inpatient hospital benefits may be paid so that each medicare beneficiary would have avail-

able to him at least 210 days of covered hospitalization, even if he had only one benefit period. As under present law, the beneficiary would be responsible for a coinsurance amount equal to one-half of the inpatient hospital deductible for each lifetime reserve day used.

The committee bill would delete the provision in the House bill requiring co-insurance payments from the 31st through the 60th day.

While the committee agrees that there is a need to more fully protect medicare beneficiaries against the high costs associated with prolonged use of inpatient hospital services and to promote the most effective utilization of such services, the committee believes that these objectives can best be accomplished with little modification in present lifetime-reserve provisions. The committee bill, therefore, would reduce the coinsurance amount applicable to lifetime reserve days from ½ to ¼ of the inpatient hospital deductible. The bill would make no change in the number of lifetime reserve days provided for under present law.

The committee believes that this approach will be of greater assistance to those seriously ill aged who can least afford a high coinsurance amount after having incurred heavy out-of-pocket costs during prolonged hospitalization. Effective professional review is the preferable approach toward preventing unnecessary or avoidable utilization.

The change with respect to the reduced coinsurance for lifetime reserve days would apply to services furnished during spells of illness beginning after December 31, 1972.

Penalty for Failure by States To Undertake Required Institutional Care Review Activities

(Sec. 207 of the bill)

The committee is concerned over the fact that there exists in many areas of the country a substantial degree of unnecessary and avoidable utilization of costly institutional care under medicaid, accompanied by insufficient usage of less costly alternative out-of-institution health care. This has been repeatedly demonstrated by investigations of the General Accounting Office, in HEW Audit Agency reports and in other testimony. As a practical matter, the Department of Health, Education, and Welfare has seldom, if ever, recovered from a State amounts improperly spent for non-covered care or services. Additionally, many States have not properly complied with utilization review and independent medical audit requirements of the medicaid program.

While Federal dollars should be used to match State medicaid dollars for the coverage of necessary institutional services under title XIX, those Federal dollars should not be used to pay for unnecessary or inappropriate institutional services.

The Committee on Ways and Means shares this concern. In order to discourage and prevent overutilization, the House bill provided for: (a) a decrease in the Federal medical assistance percentage by one-third after the first 60 days of care (in a fiscal year) in a general or TB hospital; (b) a reduction in the Federal percentage by one-third after the first 60 days of care (in a fiscal year) in a skilled nursing

home unless the State makes a showing satisfactory to the Secretary that there is in the State an effective program of controls over utilization of institutional care; (c) a decrease in Federal matching by one-third after 90 days of care in a mental hospital (except this period may be extended by an additional 30 days if the State agency certifies that the patient is receiving active treatment and will benefit therapeutically from such additional hospitalization) and provision for no Federal matching after a total of 365 days of such care during an individual's lifetime; and (d) authority for the Secretary to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

Despite general agreement with the objectives of the House bill the committee believes that the approach of the House bill needed improvement because it did not differentiate between those States which are adequately controlling utilization and those which are not, thereby unjustifiably penalizing some States.

The committee has modified the House provision so that, in addition to requiring each State to make a satisfactory showing to the Secretary that it has an effective program of utilization controls over institutional care, it would also require that States, in fact, conduct the independent professional audits of patients as mandated by present law.

The committee believes that a cutoff of Federal matching for hospital and mental hospital care utilizing arbitrary limitations would be inappropriate where the State can demonstrate that the patient needs the care and is benefiting from it. Therefore the committee has amended the House provision so that where a State makes a satisfactory showing to the Secretary that it has an effective program of control over the utilization of hospital and mental hospital care, the 60-day limitation in general and TB hospitals and the 90-day or 120-day annual limitation and the 365-day lifetime limitation on care in mental hospitals would not apply.

In view of the transfer of the title XI intermediate care facility program to the title XIX program, the committee has brought ICF services into the scope of this amendment. ICF services would be subject to a reduction in Federal matching after 60 days unless the State provides satisfactory assurance that the required review and audits are being undertaken.

To assure actual—rather than paper—compliance with these requirements, the committee amendment would require the Secretary's validation of State utilization controls and independent professional audits to be made on a sample, on-site basis in each State and that such findings be made a matter of public record.

The committee believes that this approach would differentiate between those States which are adequately controlling utilization and those which are failing to meet this objective, and would not unfairly penalize those States which have established proper controls. Thus, only those States which do not employ and apply proper utilization and medical review methods would suffer a decrease in Federal matching.

The committee has eliminated the House provision authorizing an increase in the Federal matching percentage for States contracting with health maintenance organizations or other comprehensive health

care organizations. If health maintenance organizations and other comprehensive health care organizations represent a more efficient and economical approach to the delivery of health services, increased Federal matching should not be necessary as an added incentive for the States to contract with these organizations.

The amendment would be effective July 1, 1973.

Cost-Sharing Under Medicaid

(Sec. 208 of the bill)

Under present law and regulations, States may require payment by the medically indigent (those not eligible for cash assistance because of income and resources) of premiums, deductibles and co-payment amounts with respect to medicaid services provided them, but such amounts must be "reasonably related to the recipient's income and resources." States cannot impose deductibles or co-payments on cash assistance recipients.

The House bill would require States which cover the medically indigent to impose premium charges on the medically indigent. The premium would be graduated by income in accordance with standards prescribed by the Secretary. In addition, under the House bill, States could at their option require payment by the medically indigent of deductibles and copayment amounts which would not have to vary by level of income. Finally, with respect to cash assistance recipients, nominal deductible and copayment requirements, while prohibited for the six mandatory services, would be permitted with respect to optional medicaid services.

The committee substantially modified the above House provisions.

The committee bill, as does the House bill, requires States which cover the medically indigent under their medicaid programs to impose a monthly premium enrollment fee, graduated by income, in accordance with standards prescribed by the Secretary, for those who are not eligible for cash assistance. It is expected that the amount of the premium would not serve as a barrier to entry into the program. For persons entering the program through the so-called spend-down (where medical expenses are deducted from income in determining eligibility), the amount of the premium would be considered as a medical expense. No other premium or enrollment fee could be imposed on the medically indigent under a State's plan, but States may at their option impose non-income related deductibles and co-payments on the medically indigent with respect to patient initiated elective services only. These deductibles and co-payments are expected to be of a nominal nature. The committee does not intend them to apply to inpatient hospital services, skilled nursing home care, or similar services, where the practitioner determines utilization, but only to services where the patient generally initiates use of the service, such as initial office visits to physicians and dentists for routine care. With respect to those services for which the practitioner in the main, determines utilization, the committee expects that the major control of utilization will occur through professional review mechanisms such as PSRO review.

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Limiting co-payments and deductibles for the medically indigent to modest amounts for patient-initiated elective services only is consistent with the committee's belief that such cost-sharing devices in the medicaid program should not impose such a financial hardship on the recipient that he is hesitant to seek needed medical services when he is ill. This limitation represents a modification of the House bill, which would allow States to impose non-income related co-payments and deductibles on the medically indigent for all medical services under the medicaid program.

With respect to the indigent required to be under the medicaid program, the committee believes that no premium enrollment fees, deductibles or co-payments should be imposed. The committee believes that the savings which would result from the imposition of co-payments on optional services ($5 million) would most probably be exceeded by the administrative costs.

Conditions of Medicaid Eligibility for Certain Employed Families and Newly Eligible Adult Recipients

(Sec. 209 of the bill)

Under present law, a portion of the earnings of cash assistance recipients is disregarded in determining the amount of their cash assistance benefit. These "earnings disregard" provisions are intended as an incentive for employment by public assistance recipients. However, the consequent gradual loss of cash assistance as earned income increases can have an unintended work disincentive effect at points in the earnings scale where the earning of an extra dollar can mean the phase-out of cash assistance and the loss of medicaid coverage. Just below this income point, a person might not want to seek greater earnings since additional earnings could make him ineligible for medicaid, with the result that he would lose medical benefits worth many times more than the dollar of marginal income which moved him off the cash assistance rolls. This so-called "medicaid notch" is both inequitable and a disincentive to work.

Even in States which do cover the medically indigent a problem exists, since the maximum eligibility level for the medically needy (133⅓% of the payment level) is, in a number of States, several thousand dollars below the income level where cash assistance phases out under the earnings disregard provision. Consequently, a family which has worked off of cash assistance and lost medicaid coverage would have to "spend down" to the eligibility level for the medically needy to re-establish their eligibility for medicaid.

The House attempted to remove this "notch" by requiring AFDC families with earnings to pay a medicaid deductible. In States without a medically indigent program this deductible would be equal to one-third of all earnings over $720 a year. The deductible amount is identical to the amount of earnings which AFDC families would be allowed to retain as an incentive to work. In those States with programs for the medically indigent, an AFDC recipient would not have to pay the deductible until his retained earnings exceeded the difference between a State's cash assistance level and its medically indigent level. At this

point, however, his medicaid deductible would increase dollar for dollar with his retained earnings.

Although the House provision eliminates any sudden loss of eligibility for medicaid, the provision acts as a substantial work disincentive, since the medicaid deductible increases dollar for dollar, in many cases with retained earnings. In addition, the provision would probably be extremely difficult to administer.

Therefore, the committee has eliminated from the House bill all of section 209, except subsection (d). It has developed in its stead a substitute provision designed to assure that: 1) the medicaid notch is mitigated and no longer operates as a substantial disincentive to work, 2) cash assistance recipients who are now eligible for medicaid will not lose their medicaid eligibility as a result of increased income from employment, and 3) administration of the provision will be equitable and reasonably simple. To accomplish this, the committee has added an amendment which provides that when a welfare family with children loses eligibility for cash assistance because of changes in earnings, medicaid eligibility for that family would be continued for a period of 12 months beginning with the month following the month when cash assistance was terminated, provided that such family had been recipients of cash assistance for at least three of the preceding 6 months.

The committee intends that medicaid benefits are to be available to all families who can meet the cash assistance requirements in the State (regardless of whether such family is receiving welfare cash payments, employment program payments, wage subsidy, or a work bonus). States would continue to provide medicaid coverage for the family for 1 year after their earnings increase to the point where income exceeds the relevant standard. Regular Federal matching available to States under the title XIX program would be provided for such services.

Following the expiration of the 12 months of coverage such families may elect to participate in the medicaid program by paying to the Federal Government (or to the State acting as the Federal agent) a premium equal to 20 percent of the family income in excess of $2,400 (calculated on a monthly basis). For this purpose, the amount of any work bonus (authorized by title IV of this bill) will not be considered as income. However, all other earned and unearned income, without any disregard, will be considered in establishing the amount of premium liability for the family.

The Federal Government would assume the costs of such families which are otherwise ineligible for medicaid in the State and which opt for medicaid following the end of the 12-month period to the extent that such costs exceed any premiums derived from all such families in a State. If the State has established a premium for the medically needy, in accordance with standards established by the Secretary, as set forth in section 208, that premium would be applied to these families no longer eligible for cash assistance because of increased earnings, during the 12 months of special eligibility for medicaid extended to them under this provision. No other premium could be imposed.

Similarly, employment program families otherwise ineligible for medicaid could opt for such coverage on the 20 percent premium

basis with the Federal Government assuming any additional costs of their coverage.

The medicaid services available to those families not otherwise covered under the State title XIX program and who elect to pay premiums as described above, would include the mandatory services of medicaid, subject to the limitations of duration and scope established by the State in its title XIX State plan, and such other optional services as are provided in that plan for eligible persons under the State program.

The committee has included the substance of the House amendment, which gives States the option of covering under medicaid aged, blind and disabled persons made newly eligible for cash assistance as a result of the increases in payment levels to these persons provided under title III of this bill.

No State would be required to furnish medical assistance to any individual receiving aid as a needy aged, blind or disabled adult unless the State would be (or would have been) required to furnish such assistance to such individual under its medicaid plan that was in effect on January 1, 1972. However, if a State should elect to provide medicaid benefits on the basis of its January 1, 1972 medical assistance standard it would be required to incorporate a spend-down provision comparable to that contained in section 1903(f) so that any eligible individual would be entitled to medicaid only if the income of such individual or family (after deducting incurred medical expenses) was not in excess of the State standard for medical assistance as in effect on January 1, 1972.

For this purpose, the medical assistance standard in effect on January 1, 1972 is considered to be the eligibility standard for cash assistance, or the medical assistance standard for the medically needy program (if the State has established one), whichever is higher.

Payment Under Medicare for Certain Inpatient Hospital and Related Physicians' Services Furnished Outside the United States

(Sec. 211 of the bill)

Under present law, services furnished outside the United States (defined to include the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa) are excluded from coverage, with the single exception that hospital insurance benefits are payable for emergency inpatient services provided in nearby foreign hospitals if the beneficiary is physically present within the United States when the emergency arises and the foreign hospital to which he is admitted is closer to the place where the emergency arose or is more accessible than the nearest U.S. hospital that is adequately equipped and available for his treatment.

The House-approved bill provides, with respect to admissions after December 31, 1971, for payment of medicare benefits for inpatient hospital services furnished outside the United States if the beneficiary is a resident of the United States and the foreign hospital is closer to, or substantially more accessible from his residence than the nearest hospital in the United States which is suitable and available for his treatment. For such beneficiaries, benefits would be payable without

regard to whether an emergency existed or where the illness or accident occurred. Only patient services furnished by a hospital which has been accredited by the Joint Commission on Accreditation of Hospitals or by a hospital-approval program having essentially comparable standards would be covered. (The House-approved bill would retain the provisions of present law with respect to coverage of emergency inpatient hospital services furnished outside the United States.)

Under the bill approved by the House, payment for all covered hospital services furnished outside the United States would be made on essentially the same basis as payment for emergency services furnished by a nonparticipating hospital within the United States. Where the hospital elected to bill the medicare program it would be reimbursed on the basis of the reasonable cost of the covered services furnished the beneficiary, as is now done with respect to emergency services furnished by a nonparticipating hospital which furnishes actual cost data. Where payment could not be made solely because the hospital did not elect to bill the program, benefits would be payable directly to the beneficiary on the basis of an itemized bill if he filed an acceptable application for reimbursement. Subject to the appropriate deductibles and coinsurance, the beneficiary would be reimbursed in an amount equal to 60 percent of the hospital's reasonable charges for "routine services" in the room occupied by him or in semiprivate accommodations, whichever is less, plus 80 percent of the hospital's reasonable charges for "ancillary services," or, if separate charges for routine and ancillary charges are not made by the hospital, two-thirds of the hospital's total charges.

The House-approved bill also would provide for coverage under the medical insurance program of medically necessary physicians' services and ambulance services furnished in conjunction with covered foreign inpatient hospital services, in order to assure that medicare beneficiaries would be adequately protected against other medically necessary health care costs they may incur while receiving foreign inpatient hospital care.

Payment for physicians' services would be limited to the period of time during which the individual is eligible to have payment made for the foreign hospital services he receives. Further, the Secretary would be authorized to establish, by regulations, reasonable limitations upon the amount of a foreign physician's charge that would be accepted as reimbursable under the medical insurance program. In recognition of the administrative difficulties that would arise in applying the assignment method of reimbursement to medical services furnished in other countries, the House-approved bill would provide that benefits for foreign physicians' and ambulance services would be payable only in accordance with the itemized bill method of reimbursement provided for under present law. This provision was developed by the Committee on Finance in 1970 and included in H.R. 17550 as passed by the Senate.

The committee is fully in agreement with the provisions of the House-approved bill. It has, however, added a new provision to take care of a unique problem faced by U.S. residents who, if they use land transportation to travel between Alaska and the 48 contiguous States, must travel through Canada. The committee amendment would extend coverage to emergency hospital services furnished in Canada to

U.S. residents traveling without unreasonable delay by the most direct route (as determined by the Secretary) between Alaska and another State. The Canadian hospital would have to be closer to, or substantially more accessible from the place where the emergency occurred, than the nearest hospital in the United States which was suitable and available for treatment.

These provisions would apply to services furnished with respect to hospital admissions occurring after December 31, 1972.

Demonstrations and Reports: Prospective Reimbursement; Peer Review; Extended Care; Intermediate Care and Homemaker Services; Ambulatory Surgical Centers; Physicians' Assistants; Performance Incentives

(Sec. 222 of the bill)

Prospective Reimbursement

Under present law, institutional providers furnishing covered services to medicare beneficiaries are paid on the basis of the reasonable cost of such services. Payment on this basis, with retroactive corrective adjustments, is consistent with the long history of public and private third party agency reimbursement for institutional health care on a cost basis. However, as experience under the medicare, medicaid, maternal and child health, and other third party programs has clearly demonstrated there is little incentive to contain costs or to produce the services in the most efficient and effective manner.

The committee believes that payment determined on a prospective basis offers the promise of encouraging institutional policymakers and managers, through positive or negative financial incentives, to plan, innovate and generally to manage effectively in order to achieve greater financial reward for the provider as well as a lower total cost to the programs involved. Prospective reimbursement differs from the present method of reimbursement in that a rate of payment is set in advance of the period over which the rate is to apply. The theory is that once the rate is set a provider will institute cost saving measures which will maximize the difference between its actual costs and the higher prospective rate. This difference could be expressed as the "profit." Of course, if the provider's costs turned out to be higher than the prospective rate, there would be a loss. Theoretically, this approach to reimbursement introduces incentives not present under the existing reimbursement method which, since it tends to pay whatever the costs turn out to be, provides no incentives for efficiency.

However, the committee, along with the Committee on Ways and Means, is well aware that in considering such a fundamental change in the present reimbursement method, possible disadvantages as well as the potential advantages must be taken into account. While it is clear, for example, that prospective rate setting will provide incentives for health care institutions to keep costs at a level no higher than the rates set, it is not clear that the rates set would result in Government reimbursement at levels lower than, or even as low as, that which would result under the present retroactive cost finding approach. Providers could be expected to press for a rate that would cover all the costs, including research costs and bad debts, as well as margins of safety in the prospective rates that might result in

reimbursement—if their requests were met—in excess of the costs that would have been reimbursed under the present approach. Moreover, any excess of reimbursement over costs to voluntary providers would probably be used to expand services, and the new level of expenditures might be reflected in setting higher prospective rates for future years.

Also to be considered is the fact that under prospective reimbursement it will be necessary to take steps to assure that providers do not cut back on services necessary to quality care in order to keep actual costs down and thus increase the difference between costs and the prospective rate established. The development of adequate and widely-agreed-upon measures of quality of care will clearly be needed to provide that assurance and should be immediately developed by the Department.

In view of the far-ranging implications of such a change in the approach to reimbursement, the Committee on Finance agrees with the House bill which provides for a period of experimentation under titles XVIII, XIX and V with various alternative methods and techniques of prospective reimbursement. It is the intent of the committee that experimentation be conducted with a view to developing and evaluating methods and techniques that might stimulate providers through positive financial incentives to use their facilities and personnel more efficiently, thereby reducing their own as well as program costs while maintaining or enhancing the quality of the health care provided.

The experiments and demonstration projects directed to be carried out under this provision are to be of sufficient scope and on a wide enough scale to give assurance that the results would obtain generally (but not so large or comprehensive as to commit the programs to any prospective payment system either locally or nationally). No experiment or demonstration project is to be undertaken by the Secretary until he consults with and takes into consideration the advice and recommendations of recognized specialists in the health care field who are qualified and competent to evaluate the feasibility of any given experiment or demonstration project.

Under the committee's bill, the Secretary would be required to submit to the Congress no later than July 1, 1974, a full report of the results of the experiments and demonstration projects, as well as an evaluation of the experience of other programs with respect to prospective reimbursement. The report is to include detailed recommendations with respect to the specific methods that might be used in the full implementation of a prospective reimbursement system.

Although recognizing the promise and potential offered by prospective reimbursement the committee does not wish to preclude experimentation with other forms of reimbursement. The committee believes that a solid foundation of experience is required with all possible alternative forms of reimbursement before permanent changes can be made. The bill therefore includes authorization for the Secretary of Health, Education, and Welfare to engage in experiments and demonstration projects involving negotiated rates, the use of rates established by a State for administration of one or more of its laws for payment or reimbursement to health facilities located in such State, and alternative methods of reimbursement with respect to the services of residents, interns, and supervisory physicians in teaching settings. Authority is also provided to make payments, on an ex-

perimental or demonstration project basis, to organizations and institutions for services which are not currently covered under titles V, XVIII, XIX, and which are incidental to services covered under the programs, if the inclusion of the additional services would in the judgment of the Secretary offer the promise of program savings without any loss in the quality of care.

Peer Review

The committee has eliminated the experiments in areawide or community-wide peer review authorized by the House provision as these experiments would be unnecessary in view of its approval of the Professional Standards Review Amendment.

Extended Care

The committee is concerned about the difficulties facing some beneficiaries who need extended care as a result of the present title XVIII provision under which payment may be made for services furnished in an extended care facility only if the beneficiary was transferred from a hospital after a stay of at least three days. Therefore, in addition to the other experiments the Secretary will be undertaking, the committee expects him to conduct studies and engage in experiments to determine the effects of eliminating or reducing the three-day prior hospitalization requirement, which he has authority to waive for the purpose of such experimentation, and report to the committee his findings together with any recommendations he may have for changes in this provision of existing law.

Intermediate Care and Homemaker Services

The bill would also authorize experimentation with the use of institutional and homemaker services as alternatives to more costly post-hospital benefits presently provided under title XVIII. This authority would be designed to determine the most suitable level of care for medicare beneficiaries who are ready for discharge from a hospital, or who are unable to maintain themselves at home without assistance. Experiments and projects could include (1) making payment for each day of care provided in an intermediate care facility count as one covered day of care provided in a skilled nursing facility, if that care was for the condition for which the person was hospitalized, (2) following hospitalization covering the services of homemakers for up to 3 weeks, where institutional services are not needed, (3) determining whether such coverage would effectively lower long-range costs by postponing or precluding the need for higher-cost institutional care or by shortening such care, and (4) ascertaining what eligibility rules may be appropriate and the resultant costs of application of various eligibility requirements, if the project suggests extension of coverage would be desirable. These experiments and projects would be conducted only in areas where there is effective professional control precluding inappropriate utilization, as determined by the Secretary.

Ambulatory Surgical Centers

Recently, a new type of health care facility—the ambulatory surgical center—has come into existence. This type of facility functions independently of a hospital and is primarily engaged in performing on an outpatient basis surgical procedures which usually involve the use of general anesthesia.

Under the medicare law, reimbursement for services provided in ambulatory surgical centers is limited to the reasonable charges for physicians' services. No reimbursement is made for costs attached to the facility itself—that is, cost of the operating room, the recovery room, or other space provided. The committee believes that such facilities may meet a useful need, in economical fashion, in the health care delivery system. However, the committee believes that it is advisable to defer consideration of this type of facility as a provider of services under medicare until the concept of an ambulatory surgical center can be further evaluated. At present there is a lack of agreement among professional people as to the feasibility and desirability of these centers.

The committee added to the House bill a provision which would authorize the Secretary to conduct a study of the various types of facilities (such as the Surgicenter in Phoenix, Arizona) engaged in providing surgical or other services to ambulatory patients. If, as a result of this study, the Secretary finds that coverage of presently noncovered services provided by one or more types of ambulatory surgical or health care centers offer promise of improved care or more efficient delivery of care and would not result in cost to the program in excess of what would otherwise be incurred for such services, he would be authorized to enter into an arrangement with one or more of such facilities to conduct a demonstration project to determine the best method of reimbursing such facilities under medicare.

Physicians' Assistants

Under present law, part B of medicare pays for physicians' services. Within the scope of paying for physicians' services, the program pays for services commonly rendered in a physician's office by para-medical personnel. For example, if a nurse administers an injection in the office, medicare will recognize a small charge by the physician for that service.

Medicare will not pay where a physician submits a charge for a professional service, performed by a para-medical person, in cases where the service is traditionally performed by a physician. For example, the program would not recognize a charge for a complete physical exam conducted by a nurse.

Additionally, medicare will not recognize a physician's charge for a service performed by a para-medical person outside of the physician's office. In other words, he would not be reimbursed for an injection administered by a para-medical employee in a nursing home.

Over the past few years, a number of programs have been developed to train physicians' assistants. These assistants are seen as a way to extend the physician's productivity and to bring necessary care to many who would otherwise not receive it. HEW is currently supporting the training of these physicians' assistants. There are some 100 experimental training programs for physician assistants and nurse practioners. Each of these, however, is structured differently, reflecting the lack of agreement among professionals on the experience and education that should be required of training program applicants, the content of the programs, or the responsibilities and supervision that are appropriate for their graduates. These unresolved issues have prompted the American Medical Association, the American Hospital Association, the American Public Health Association, as well as the

Department (in its "Report on Licensure and Related Health Personnel Credentialing") and other organizations to ask for a moratorium on State licensure of the new categories of health personnel.

Some feel that it is inconsistent for HEW to support the training of these personnel, while medicare does not, in some instances, recognize all their services as reimbursable items.

Others argue that medicare does reimburse physicians for services provided by these new physicians' assistants, so long as they are services commonly provided by para-professional personnel in a physician's office. They contend that, until the training and licensure of physicians' assistants becomes more uniform, it would be inappropriate for medicare to take the lead in encouraging doctors—by generous reimbursement—to use physicians' assistants to work independently or to expand their responsibilities.

The committee has included a provision authorizing demonstration projects to determine the most appropriate equitable methods of compensating for the services of physicians' assistants. The objectives are development of non-inflationary alternatives which, if accepted for general use, would not impede the continuing efforts to expand the supply of qualified physicians' assistants.

Reimbursement under these demonstration projects would not be made to physicians for services performed by physicians' assistants unless such services are of kinds performed independent of the employing physician's immediate supervision and unless such assistants are clearly trained and legally authorized to specifically perform those independent services.

In addition it would seem inappropriate to reimburse a physician his regular fee-for-service rate if the service was performed wholly by the physician's assistant. This would merely serve to vastly increase and inflate medical care costs in large part by increasing physicians' incomes.

Medicare would be given demonstration authority to study, develop, and make such types of reimbursement on a demonstration basis as might serve to provide bases for equitable, economical and non-inflationary compensation for the independently rendered services of physicians' assistants.

Carrier Performance Incentive Contracts

Authority is also provided to experiment with the use of fixed price or performance incentive contracts to determine whether they would have the effect of inducing more effective, efficient and economical performance by carriers and intermediaries.

Financing

It is intended that benefit costs and administrative costs incurred under this section would be paid out of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund for projects for services delivered to medicare patients.

Demonstration projects for prospective reimbursement for services delivered to medicaid and title V recipients would be financed with funds appropriated under titles XIX and V of the Social Security Act. To the extent that joint projects are funded, involving medicare beneficiaries as well as medicaid and title V recipients, the cost would

be appropriately divided between the trust funds and the other two titles.

The Secretary is to submit to the Committee on Ways and Means and the Committee on Finance, for their information, plans for each experiment or project authorized under these provisions, including a description, in detail, of its nature, methodology, and objectives. The intent is that there be an opportunity for congressional study—rather than approval—before the experiment or project is put into operation.

Payments to Health Maintenance Organizations

(Sec. 226 of the bill)

Introduction

Under present law, organizations providing comprehensive health services on a per capita prepayment basis cannot be reimbursed by medicare through a single capitation payment such as the organizations normally charge for services covered under both the hospital insurance and supplementary medical insurance parts of the medicare program. Instead medicare reimbursement to group practice prepayment plans may not exceed the costs to the organization of providing specific services to beneficiaries, so that any of the financial incentives which such organizations may have in their regular nonmedicare business to keep costs low and to control utilization of services are not fully incorporated directly in their relationship with medicare.

Of course, the committee believes that a proper sense of professional responsibility also should obtain in patient care and should be of greater significance than economic incentives in assuring appropriate utilization of health care services.

Nonetheless, a disincentive to control of costs and utilization of services occurs to an extent in the present, usual approach to payment for services in the health field where payment is made to the provider for each individual service performed, so that other things being equal, there is an inherent economic incentive to provide services which may not be essential, and may even be unnecessary.

Because the comprehensive care organization receives a fixed annual payment from enrollees, regardless of the volume of services rendered, there is a financial incentive to the organization, by its administrative supervision and review, to control costs and to provide only the least expensive service appropriate to the enrollee's needs. The incentive to the organization may be passed on to the doctor by paying him on a salary basis or providing a bonus or similar profit-sharing arrangement when costs are kept low. On the other hand, there is also present in such systems an economic incentive to provide less care than is necessary so as to reduce costs and further maximize financial gain; thus, a strong need exists to provide effective assurances of proper care.

The committee believes it is desirable for medicare to relate itself to prepayment health care organizations in a way which conforms on a closer basis to their usual way of doing business, and agrees with the concept, embodied in the House bill, of making a health maintenance organization (HMO) option available to medicare beneficiaries.

The HMO amendment to the Social Security Act does not purport to serve as the definitive legislation or otherwise limit organizations

which might be termed HMO's for purposes of organized delivery of health care. Such organizations may assume a variety of guises and play a varying range of roles. The purpose of this amendment is solely to establish a mechanism for determining *which* HMOs are acceptable for incentive reimbursement under medicare. It is an amendment intended to protect beneficiaries and public trust funds—in fulfillment of the committee's responsibilities.

The committee's study of the House provision reveals a number of serious problems with respect to HMO's which should be remedied. Consequently the committee has made several modifications in the HMO provision designed to reasonably safeguard the interests of the public programs and beneficiaries while, at the same time, encouraging the development and recognition of qualified HMO's. The major modifications fall into two general areas—reimbursement of HMO's and assurance of quality of care.

Under the House provision, medicare payment to a health maintenance organization with respect to beneficiaries enrolled with it would be made on a prospective per capita basis, encompassing all medicare-covered services, determined annually in accordance with regulations of the Secretary, at a rate equal to 95 percent of the estimated amount that would be payable if such covered services were furnished outside of the framework of a health maintenance organization. Within this payment, the rate of retention (gross revenue less costs) on medicare enrollees would not be permitted to exceed the rate on other enrollees of the health maintenance organization. The Secretary would examine the relative rate of retention, as determined by generally accepted accounting principles, after each accounting period and any excess retention realized on behalf of medicare beneficiaries must be applied toward additional benefits or reductions in premiums charged to medicare enrollees or refunded to the trust funds.

The committee has several basic reservations about the House provision for HMO reimbursement. First, it is clear that the actuarial adjustment process used to determine the amount payable to the HMO will not be of sufficient precision for the purpose—certainly during the first several years. Factors such as enrolling the disabled and covering the cost of maintenance drugs would involve estimates with which experience is very limited. If an HMO were to enroll relatively good risks (i.e., the healthier medicare beneficiaries), payment to that organization in relation to average per capita non-HMO costs—without accurate actuarial adjustment—could result in large "windfalls" for the HMO as the costs of caring for these beneficiaries might turn out to be much less than medicare's average per capita costs. A similar windfall might accrue if the HMO were to offer poorer than average service or less qualified physicians than those generally utilized in an area. Errors of estimate might also go against the HMO, even though the HMO's would strongly resist accepting a level of reimbursement which involved a high risk of loss. Furthermore, changing enrollment or conditions of enrollment could have significant cost effects on all but the largest HMO's.

Once a valid reimbursement rate is determined, a second issue remains as to the extent to which the HMO and the Government should share in any savings achieved by the HMO.

Reimbursement

To more adequately respond to the full range of legitimate reimbursement needs of HMO's, the committee bill would provide for two methods of reimbursement, each designed for a particular type of organization. One method of reimbursement, available to HMO's which have reasonably demonstrated a capacity to provide health care of acceptable quality in an organized and effective manner, would relate the ultimate payment directly to the actual costs of a similar beneficiary population outside the HMO, providing a formula-incentive payment when the HMO achieves savings compared with average costs of health care delivery. The other reimbursement provision is designed primarily for newly established HMO's whose operating experience and medicare population are not sufficient to provide a satisfactory base for actuarial rate determination or to assure ability to deliver health care services effectively and economically. Start-up costs would normally have the effect that no savings over outside costs could be achieved soon after the development of an HMO. Therefore, this reimbursement provision was designed to give such organizations experience with the capitation payment mechanism but would tie the ultimate medicare payment directly to actual costs incurred by the HMO for the types of expense allowable under medicare on behalf of its medicare enrollees.

Under the reimbursement provisions developed by the committee, the Secretary would be authorized to contract on a prepaid per capita basis for medicare services with substantial, established HMO's: (1) with reasonable standards for quality of care at least equivalent to standards prevailing in the HMO's area, and which can be adequately monitored, and (2) which have sufficient operating history and sufficient enrollment to provide an adequate basis for evaluating their ability to provide appropriate health care services and for establishing a combined part A-part B capitation rate. Such reimbursement would be authorized for HMO's which: (1) have been providing for at least 2 years, a comprehensive range of services similar to those required to be provided to medicare enrollees under this provision and (2) have a minimum of 25,000 enrollees, not more than one-half of whom are age 65 or over.

The Secretary would be authorized to make exceptions to the minimum enrollment requirement only in the case of HMO's in smaller communities or sparsely populated areas which had demonstrated through at least 3 years of successful operation, capacity to provide health care services of proper quality on a prepaid basis (even though they may not have actually provided such care on this basis to any large number of people for an extended period) but which have at least 5,000 members. This would enable organizations with proved ability to be eligible for participation as an HMO. An HMO could be considered to serve a sparsely populated area if it is located in a nonmetropolitan county (that is, a county with fewer than 50,000 inhabitants), or if it has at least one such county in its service area, or if it is located outside of a metropolitan area and its facilities are reasonably accessible to less than 50,000 people.

HMO's with fewer than 25,000 enrollees would present special problems because of the difficulty of determining a valid rate on a relatively

small population base, and because such organizations will have less in-house capacity to provide medical specialty services. Accordingly, exceptions to the 25,000 minimum enrollment principle in rural or sparsely populated areas should be contingent on a finding by the Secretary that the HMO (1) has established effective referral mechanisms to assure that its enrollees have the benefit of appropriate specialty services so that they are not disadvantaged with respect to quality of care as compared with other residents of the same geographical area, and (2) has operating experience and an enrolled population sufficient to provide a reasonable basis for establishing a valid reimbursement rate. Reimbursement to the HMO would be related to the costs of services for the types of expenses allowable under medicare for a non-member population that receives services normal for the specific area or similar areas.

Reimbursement: Established HMO's

An organization which qualifies as an "established" HMO would be eligible to contract with the Secretary for reimbursement on an incentive basis. Under this provision, the HMO would submit, at least 90 days prior to the beginning of a prospective medicare contract year, an operating costs and enrollment forecast. On the basis of the estimate and available information regarding medicare costs in its area, the HMO and the Secretary would arrive at an interim per capita reimbursement rate. The rate, which would be payable monthly, in advance, would reflect estimated costs of the HMO for its enrolled population but might not exceed 100 percent of the estimated "adjusted average per capita cost." If the HMO failed to submit the required cost data on a timely basis, the Secretary could reduce the interim payments as appropriate until the necessary information was submitted and an equitable interim reimbursement rate determined.

The initial cost estimates would be updated by the HMO (using reasonable estimating procedures satisfactory to the Secretary) on a quarterly basis, during the contract year to reflect any substantial changes in actual costs compared with the estimates. Interim payments to the HMO would be adjusted as indicated in such reports, subject also to the estimated adjusted average per capita cost ceiling.

At the end of the fiscal year the HMO would submit independently certified financial statements, including certified cost statements allocating allowable types of operating costs (on an incurred basis) to the medicare population. Allocations may use utilization data, statistics, and methods of analysis acceptable to the Secretary in lieu of allocations based upon charges in the case of an HMO which does not operate on a fee-for-service basis. Such statements would be developed in accordance, generally, with medicare accounting principles. All HMO's would be subject to audit in accordance with the selective audit procedures of the Bureau of Health Insurance and would also be subject to audit and review by the Comptroller General and the Inspector General for Health Care Administration.

The Secretary would retroactively determine, on an actuarial basis, the "adjusted average per capita cost" incurred for the fiscal year; that is, what the average per capita costs for part A and part B services

would have been if the HMO's medicare beneficiaries had been served through other health care arrangements including other HMO's in the same general area. Where the area was significantly underserved and the HMO provided adequate service, costs of adequate service in other areas would be taken into account.

The committee recognizes that, in the early stages of administration of the HMO provisions, the number of individual actuarial adjustment factors which can be effectively applied in making such calculations will be more limited than will be the case subsequently. At a minimum, however, the actuarial determination would include, in addition to adjustment for geographic variations, adjustments (determined and applied separately for part A and part B services) for age and sex distribution and institutional and disability status of the enrolled beneficiary population. Social security data could be used to obtain information on these characteristics. As additional experience is acquired, adjustments should also take into account other factors such as the extent of use of specialists as compared to general use of specialists in the area and, the extent of the use of interns or residents. Also, in the initial stages of implementation, the definition of "area" used in calculating non-HMO costs may not adequately take account of the particular circumstances of individual HMO's. For example, if "area" were defined as the county or counties included in its service area, an HMO providing services in a high-density, high-cost location might be unduly penalized because the county in which it was located was largely rural and low-cost. It is expected that as the actuarial methodology is refined, the definition of area will be modified so as to prevent an HMO from being either penalized or rewarded by anomalies.

If the HMO's incurred costs are less than the adjusted average per capita cost, the difference, called "savings," would be divided between the Government and the HMO in accordance with a prescribed formula. Savings between 90 percent and 100 percent would be divided equally between the Government and the HMO. Savings between 80 and 90 percent would be divided 75 percent to the Government and 25 percent to the HMO. Savings below the 80-percent level would be allocated entirely to the Government. Thus, assuming an HMO operated at 80 percent of adjusted average per capita costs, it would receive a bonus equal to 7½ percent of the adjusted average per capita costs. Of course the 7½ percent of outside costs would represent a bonus of almost 10 percent in terms of the HMO's costs.

At the option of the HMO, it could apply any amount of its bonus toward improved benefits, reduced supplemental premium rates, other advantages for beneficiaries, or retain the money. It could not, however, make cash refunds to beneficiaries.

If, on the other hand, HMO costs exceed adjusted average per capita costs, the "excess costs" would also be allocated. The amount of excess costs between 100 percent and 110 percent would be divided equally between the Government and the HMO. Excess costs between 110 percent and 120 percent would be borne 25 percent by the HMO and 75 percent by the Government. Costs in excess of 120 percent would be

borne entirely by the Government. Any losses incurred would carry forward and be recovered from future favorable experience. Thus, any losses by the Government would be recovered in full before any bonus could be paid to an HMO in future years.

In aggregate effect, this committee provision for reimbursing HMO's differs from the House version in two basic respects. First the House version provides that comparative economies achieved by the HMO will be allocated to one or more of three groups—the beneficiary, the HMO and the Government—whereas the committee version would mandate a two-way sharing of savings between the HMO and the Government. The committee believes that the HMO itself would be in the best position to decide whether to allocate part of its bonus to the beneficiary. One organization might decide to use its incentive bonus to offer additional benefits to medicare enrollees, another to attract personnel, or expand facilities. In this regard, the committee is also concerned with the real possibility that, under the House version, beneficiaries might get additional benefits following receipt of incentive payments for a "good" year and would count on them only to have them taken away in the next "bad" year.

While the committee believes it is not improper for medicare to offer the possibility of profit to a health care deliverer if there is reasonable expectation that this approach will benefit the program generally, it does not believe that medicare should, by statute, favor one group of beneficiaries over another. Mandating increased benefits in an HMO as the House bill would have done could have that effect, since it would result in some of those beneficiaries who have had an opportunity to enroll in certain HMO's being mandated advantages in the form of extra benefits over persons who did not choose or have an opportunity to enroll in such an HMO even though they may have used service arrangements—including efficient fee-for-service practitioners and providers—with as low or lower costs than some of the HMO's.

The second basic difference between the House version and the committee provision for incentive-based reimbursement lies in the allocation of differences between the HMO's costs and costs of other beneficiaries. On this point, the committee believed that the provision should be more equitable to the HMO and Government throughout the full range of possible outcomes and should not provide as potentially significant an incentive to underservicing or inadequate service as does the House version. The committee approach calls for sharing of both savings and losses in an individual contract year, with provision for recouping any prior "loss" amount from future savings. By contrast, the House provision places the entire loss burden (plus the 5 percent difference between full outside per capita costs and the 95 percent payment rate) directly on the HMO with no provision for subsequent recoupment of prior losses. This places a significant risk of insolvency or inability to provide contracted-for services during a "bad" year on the HMO with limited financial reserves. The following table shows the difference in gain (or loss) earned, House and committee versions, assuming the gain in nonmedicare business equals or exceeds the profit on medicare:

COMPARISON OF GAINS (OR LOSSES) TO AN HMO UNDER THE HOUSE AND FINANCE COMMITTEE VERSIONS AT SELECTED LEVELS OF COST

If an HMO's cost as a percent of outside costs is—	Under the House version		Under the Finance Committee version	
	The HMO's gain (or loss) as a percent [1] of outside costs will be—	The HMO's gain (or loss) as a percent [1] of its own costs will be—	The HMO's gain (or loss) as a percent [1] of outside costs will be—	The HMO's gain (or loss) as a percent [1] of its own costs will be—
120	(25)	(21)	(8)	(7)
110	(15)	(14)	(5)	(5)
105	(10)	(10)	(3)	(2)
100	(5)	(5)	----	----
97	(2)	(2)	2	2
95	----	----	3	3
92	3	3	4	4
90	5	6	5	6
88	7	8	6	6
85	10	12	6	7
80	15	19	8	9
50	45	90	8	15

[1] Rounded to the next full percent.

As the table shows, the committee version is more favorable than the provision in the House bill when HMO costs are more than 90 percent of outside costs. The House version may offer large incentives—as much as a 90 percent excess payment above HMO cost—if services to the aged (and nonmedicare members) are greatly reduced.[1] The committee approach is based on the belief that such a reduction is likely to be detrimental to the aged. Research in costs of health care for the aged shows no such potential saving if adequate services are provided when needed.

It is intended that the medicare program make every effort to achieve prompt final settlements with HMO's at the end of their fiscal years. However, program experience indicates that processing of detailed cost reports and the inevitable time lag between the close of a fiscal year and the availability of data on non-HMO costs could produce substantial delays in final settlement. Therefore, the committee has included a provision which would assure that the efficient HMO realizes full value of its share in program savings (even though incentive bonuses would be paid only at the close of the year); that HMOs suffer no financial disadvantage through delayed settlement when an additional sum is payable at year's end; and that the Government suffers no loss when repayment of an overpayment is delayed.

The committee expects that, within 90 days following close of the accounting period, an interim settlement would be reached on the basis of the best available data; 50 percent of any estimated residual amount due the HMO or Government under the sharing formula would be paid at that time. For purposes of the interim settlement, the HMO's per capita incurred costs during the course of the year (or, if feasible, a reestimate at the end of the year) would be compared with the updated estimated adjusted average per capita incurred cost outside the HMO, which serves as the ceiling in determining capitation payments, to make a tentative determination of payment or repayment due. Final

[1] It should be noted that the gain under the House version may actually not be as large as indicated because it could not exceed the retention in nonmedicare business.

settlement, including payment of additional savings or underpayment of cost due the HMO, as well as overpayments recoverable by the Government, would take place as soon as feasible following accumulation of sufficient data necessary to assure reasonably precise actuarial determinations of per capita expenses within and outside the HMO. Any amount due at the time of final settlement would be paid with interest accruing from the 91st day following the close of the year and would be payable at the average rate of interest payable on obligations of the Federal Government if issued on the 91st day for purchase by the medicare trust funds. Thus, the HMO would not suffer financial penalty from delays in final settlement before full payment is made of savings, nor would the Government gain by such delay.

Reimbursement: New HMO's

The committee believes that, in general, HMO's with less than 2 years' operating experience are not apt to have a medicare population sufficient to provide a satisfactory basis for evaluating their actual ability to deliver health care services in satisfactory fashion to beneficiaries and for actuarially sound rate determination. Nor will their operating experience be sufficient to provide a proper basis actuarially for estimating financial requirements for a year in advance. Thus, a per capita reimbursement rate would be difficult to develop and administer, and would involve uncertainty.

However, it seems appropriate to permit a new HMO, at its request, to function under "costs only" per capita rate system of payment so that the organization can become accustomed to planning and functioning on the basis of a predetermined budget rather than in traditional fee-for-service terms. Accordingly under the committee bill, an alternative reimbursement provision authorizes the Secretary to contract with developing HMO's for an interim periodic payment method of reimbursement to cover both part A and B services (provided the HMO undertakes responsibility for providing or arranging for such services). This payment would be interim only and would be subject to adjustment at the end of the contract period to reflect the HMO's expenses otherwise reimbursable under title XVIII of providing covered services to its medicare enrollees.

Under this option, developing HMO's would neither have an opportunity to profit nor be at risk. At the same time, HMO's in the developing category might, of course, be eligible for grant, loan, and loan guarantee assistance.

After at least two years of providing comprehensive services and when its enrollment reaches a minimum of 25,000, such HMO's would become eligible to apply for reimbursement as established HMO's. The same would be true after 3 years of operation in the case of HMO's in smaller communities and sparsely populated areas with 5,000 enrollees under the exception provisions previously discussed. The 2 or 3 year operating period would not be deemed to commence until the organization was, in fact, serving a sufficient number of enrollees to provide an adequate basis for accurately projecting per capita costs. Ordinarily such period would begin with the time when it has enrolled about one-third of the minimum enrollment requirements.

The Secretary would issue regulations defining the conditions a developing HMO would have to meet in order to qualify as potentially eligible for reimbursement on an incentive basis. It is contemplated that the developing HMO would not have to completely meet the standards required for participation as an established HMO. For example, it would not be required to provide as comprehensive a benefit package as the established HMO, nor would it be required to operate primarily on a prepayment basis, although it would need to be providing services to an enrolled population or have some other method acceptable to the Secretary of providing a sound base for making proper cost projections.

Since the developing HMO could not be assumed to provide all the services or meet the standards of established HMO's, if beneficiaries enrolled in developing HMO's obtained services covered under medicare from sources other than the HMO, these outside services would be paid for by the medicare program if not covered by the HMO; that is, the enrollees would not be "locked-in" to the developing HMO. The developing HMO, as previously noted, would not be eligible for incentive payments until fully qualified. It is expected, of course, that the various elements of a developing HMO, such as a hospital, skilled care facility, or clinical laboratory, would, like the elements of a risk-sharing HMO, have to meet the conditions of participation or other quality standards which apply to such organizations under present law. It is also expected that the Secretary's regulations would be designed to assure that only organizations which offer a reasonable prospect of eventually fully meeting the statutory definition of an HMO would be permitted to participate for purposes of medicare as a developing HMO.

To provide needed flexibility, the committee provision would also permit new HMO's which are divisions or subsidiaries of an established HMO and for which an established HMO is willing to assume responsibility for financial risk and assurance of adequate management and supervision of health care services to be treated the same as an established HMO and would not be required to demonstrate actual experience as independent units. In addition, two or more independent HMO's would be permitted to combine through merger or effective affiliation arrangements in order to satisfy the minimum enrollment standard. As in the case of the limited exception to the minimum size requirement previously discussed, the Secretary would be expected to exercise careful judgment to assure that the relationships between established and new HMO's or between two or more smaller HMO's which wish to combine to meet the 25,000 member standard are effective and viable, rather than pro forma.

Reimbursement: General

Under the reimbursement provisions of the committee bill, the per capita cost determinations will, as under the House provision, recognize as allowable reasonable costs only those types and items of expense allowed under medicare generally.

The committee expects that a return on equity capital would be payable to proprietary ECF's and hospitals owned by an HMO under the same regulations applicable to such facilities under the principles

of reimbursement for provider costs under the regular medicare program. The committee would emphasize that reimbursement to HMO's would, as is all reimbursement under title XVIII, be subject to standards of reasonableness, and the Secretary would be expected to assure, by means of postpayment audits on a sample basis or by other appropriate procedures, that the allowable costs incurred by HMO's in providing and arranging for services for medicare beneficiaries are not excessive. The Secretary would, of course, be expected to establish regulatory guidelines as to the reasonableness of incurred costs in certain areas where there is a substantial possibility of abuse, as he does under existing law. An example of a cost item where the Secretary would be expected to establish reasonable limits would be the amount of net profit allowed in the reimbursement of physician partnerships (or other forms of medical group practice) and compensation of the physicians involved which the HMO would be allowed to include as a cost under medicare.

Another potentially troublesome area might be costs incurred by organizations related to the HMO. To avoid excessive payments in the case of related organizations (those with overlapping financial interests, either direct or indirect) the committee provision requires that all HMO financial statements called for be submitted on a consolidated basis, disclosing costs, and charges if different, pertaining to medicare services furnished by the related organizations. In addition, the Secretary could recover or adjust amounts found on the basis of comparative data to constitute excess payment (using in general, medicare limitations on such payments) to related organizations, owners, controllers or sponsors of the HMO.

An HMO which arranges for part A institutional (hospital and skilled nursing facility) services would be free to negotiate payment rates, subject to certain limitations. If the institution is an affiliated unit, the consolidation provisions, and restrictions on payments to related organizations and excessive compensation would apply. If the HMO maintains that it should compensate an institution at a level greater than the regular medicare level of payment (or equivalent) to that institution it would be required to provide justification satisfactory to the Secretary that a reasonable return was received for the excess payment.

Where the HMO finds this a more feasible and economical arrangement, it would have the alternative of letting the Social Security Administration pay for part A institutional services directly under the medicare payment system, and charge the HMO's account for such services.

The committee notes that some HMO's will provide a substantial number of services to non-HMO enrollees on a fee-for-service basis and that there will also be cases in which, although the HMO itself might not be providing substantial amounts of such services to non-enrollees, the physicians with whom the HMO enters into contractual arrangements to provide comprehensive services, and the facilities used to provide such services, may be identical with those used to provide fee-for-service services to non-enrollees. Such situations would raise the possibility of an HMO's encouraging high-risk individuals to withdraw from the HMO with the understanding that they receive the

same services from the same individuals and in the same setting, but have payment made under the regular medicare program. One method of preventing this type of situation would be to place limits on reimbursement under the regular medicare program in such cases. However, the committee does not think this would be desirable. Nor does it want to prohibit an HMO from providing services to non-enrollees on a fee-for-service or other non-capitation basis. Rather, it intends that the Secretary identify HMO arrangements where the possibility of this type of situation exists, and establish policies—such as a requirement for statistical comparisons of the cost and utilization of HMO and non-HMO beneficiaries in such settings—which would minimize the likelihood of, and facilitate identification of this type of problem. If such abuse is found, and is not promptly rectified, the Secretary would be expected to report his experience with such problems in his reports to the Congress on the HMO provision.

In general, medicare reimbursement principles applicable to overhead items would be applied in determining acceptable HMO costs. In view of the open enrollment requirements under which HMO's will need to communicate with medicare beneficiaries in their service areas regarding open enrollment periods, reasonable costs incurred in satisfying the open enrollment requirement would be treated as allowable administrative costs. On the other hand, any reinsurance costs—including underwriting of risk above 100 percent of adjusted average per capita costs—would not be treated as allowable cost for HMO cost determination purposes with the exception of reinsurance of out-of-area costs.

Before approving an HMO for contracting on an incentive per capita reimbursement basis the HMO should submit evidence that it is financially responsible and will be able to carry out its contractual commitments. The committee believes that, at a minimum, the HMO should be able to present evidence satisfactory to the Secretary of capacity to assume its proportionate share of risk on up to 20 percent above total estimated adjusted average per capita costs during the prospective medicare year. This could include calculations based upon capacity to provide covered services apart from actual financial resources. Also, an HMO should not be permitted to switch back and forth between the per capita rate reimbursement system and the regular cost reimbursement system, depending upon which appears more advantageous at any particular time. Accordingly a provision has been added to permit an HMO which has commenced contracting on a risk-sharing basis to switch back to the regular reimbursement basis but subject to the condition that it could not again be accepted to contract on a per capita rate basis.

Definition of HMO

Under the House and committee bill, to qualify for reimbursement as an HMO, the organization must be one which provides: (1) either directly or through arrangements with others, health services on a prospective per capita prepayment basis and (2) physician's services, for the most part, rendered either directly by physicians who are employees or partners of the organization, or under an arrangement with an organized group of physicians under which the group is reimbursed for its services primarily on the basis of an aggregate fixed

sum or on a per capita basis. It is expected that such payment arrangement would contain an element of incentive for such physicians to assure that medicare patients are provided needed services in the most efficient and economical manner. (The group of physicians which has the arrangement with the health maintenance organization could, in turn, pay its physician members on any other basis, including fee-for-service.) Some specialist physician services could, as is often the case in existing HMO's, be purchased from physicians as needed on a fee-for-service or fee-for-time basis.

Other provisions in the House and committee bill require that the various elements of a health maintenance organization, such as the hospital, the skilled care facility or clinical laboratory, would each continue to have to meet the conditions of participation or other quality standards which apply to such organizations under present law. Also, a health maintenance organization must have at least half of its enrolled membership under age 65 or be expected to meet this requirement within a period not exceeding 3 years with evidence of positive and continuing efforts to achieve the required enrollment distribution. Additional requirements are: (1) that the organization furnish to the Secretary proof of its financial responsibility and its capacity to provide comprehensive health services, including institutional services, effectively and economically; (2) that the organization assure that the health services required by its enrollees are received promptly and appropriately and that they measure up to proper quality standards.

Under the committee provision, the HMO would have to maintain an appropriate mix of primary care and specialty care physicians in relation to its size and in relation to the physician manpower mix in the general geographical area; physicians should not be classified as specialists unless they are board certified or eligible for specialty board certification; provided, however, that for good cause and under unusual circumstances the Secretary might recognize a physician as a specialist if, in fact, such physician can show substantial equivalence of training and experience, and a record of demonstrated proficiency.

The HMO would be expected to assure that the appropriate mix of specialists is properly assigned and utilized. Thus, for example, in an area where major surgery is generally done by board eligible or board certified surgeons, the same situation should prevail in the HMO except in cases of emergency or other highly unusual circumstances.

The HMO should have effective referral arrangements to assure that members would, in cases of medical necessity, have access to qualified practitioners in those specialties which are generally available to the general public in the service area but not included within professional staff directly associated with the HMO.

The committee made clarifying modifications in two other portions of the House definition of a health maintenance organization. A provision of the House bill which would require the HMO to provide all the services and benefits covered under both part A and part B has been modified to require it to provide all such services which are generally available to persons residing in the area served. Thus, for example, if there were no home health agency in the area, the HMO would not be required to create such an agency solely for its medicare enrollees. The committee also modified a House requirement that the HMO hold an

annual open enrollment period during which applicants would be accepted on a nondiscriminatory basis up to the limits of capacity. The House bill authorizes an exception to this requirement if acceptance of all applicants would result in an HMO enrollment of more than 50 percent of individuals over age 65; the committee would also permit the HMO to limit acceptance of applicants from any particular age group to prevent its membership from becoming substantially non-representative of the geographic area which it serves. Generally, a subgroup of enrollees would not be considered to be non-representative unless its proportion among all enrollees exceeds by at least 10 percent its proportion in the general population in the area.

Other Provisions

The committee agrees with the House that the Secretary should issue regulations establishing means for effective implementation of an ongoing review program to assure that the health maintenance organization effectively fulfills beneficiary service needs by adhering to specified requirements for full-time qualified medical staff, keeping beneficiaries fully informed on the extent of coverage of services received outside the organization, taking positive actions to avoid any possibility of beneficiaries being deprived of benefits through devices such as scheduling appointments at inconvenient times or unwarranted delay in scheduling of elective surgery, and avoiding discrimination against poor health risks through selective enrollment or poor service aimed at encouraging disenrollment of high users of services.

In addition, while the committee recognizes the desirability of permitting considerable latitude in organizational arrangements, it also expects that the Secretary's regulations will require organizations, such as medical foundations, which furnish a significant amount of institutional or other services under arrangements, to provide sufficient management and coordination of services to assure that the full range of covered care, to the extent generally available in an area, is provided as needed to the beneficiary population.

The individuals with respect to whom medicare would pay capitation payments are medicare beneficiaries who are entitled to both hospital insurance and supplementary medical insurance or to medical insurance only and who are enrolled with an HMO. Under the House bill, such enrollees would receive medicare-covered services only through the health maintenance organization, except for those emergency services as are furnished by other physicians and providers of services. The HMO would be responsible for paying the costs of such emergency services.

The committee has made this House-passed requirement applicable to HMO's which have contracted on a risk-sharing basis and has added a provision which would also require the HMO to assume expenses for "urgently needed" services received by a medicare enrollee who is temporarily outside the HMO's service area. Services covered under this provision would generally be those services which, while not "emergency" to the extent of requiring use of the most accessible hospital in order to prevent death or serious impairment of health, are nevertheless immediately necessary to prevent serious deterioration of health and cannot feasibly be provided at the HMO's treatment facili-

ties because of the beneficiary's temporary absence from the service area, such as during a vacation trip. If an enrolled individual received care other than emergency or urgently needed services, through some other means than the health maintenance organization, he would have to meet the entire expense of such care, except in the case where a determination has been made that the individual received care outside the HMO which should have been furnished by it but was not made reasonably available.

The committee recognizes that many medicare beneficiaries are highly mobile, so that restrictions on out-of-area coverage by the HMO may well be seen by beneficiaries as a serious disadvantage and may also be difficult for beneficiaries to fully understand when they are considering whether to enroll in an HMO. It is also recognized that an HMO would generally have little chance of exercising control over costs of urgently needed services received by medicare beneficiaries, other than through restrictions on the extent to which such services are covered. Therefore, in order to encourage an HMO to provide as full coverage of urgently needed out-of-area services as it feasibly can, it would be permitted to reinsure such costs, provided that its coverage of them meets the minimum requirements which the Secretary would establish in regulations. Also, the Secretary would be expected to consider the feasibility of permitting HMO's to enter into arrangements to have payment for out-of-area services to beneficiaries made through the regular medicare program, with appropriate adjustments made in the HMO's account; the Secretary would be authorized to implement such a system, if he determined that it would be administratively feasible.

The committee also realizes that some HMO's may not be able to provide urgently needed services to beneficiaries who are temporarily outside their service area, because they cannot obtain reinsurance for these costs or for other good reasons. While under the House bill an HMO that could not provide emergency services to such beneficiaries could not qualify as an HMO, the committee believes that such a result would be unfortunate, especially since there does not seem to be a very strong precedent for coverage of such services among prototype HMO's. The committee believes that otherwise qualified organizations that are unable, for good reason, to provide coverage of urgently required services furnished outside the HMO area should nevertheless be permitted to participate as HMO's. In such cases, out-of-area covered services received by beneficiaries enrolled in such an HMO would be payable under the regular medicare program. The capitation payable to such organizations should be adjusted to exclude an amount estimated to represent costs of covered services which the HMO's beneficiaries receive outside the HMO's service area. The committee would expect the Secretary to take any necessary precautions to assure that this provision was not used by HMO's to encourage beneficiaries to secure certain high-cost medically necessary services from outside the HMO.

If the HMO provides only the services covered by the medicare program to its enrollees, the premiums or other charges it makes to its enrollees cannot exceed the actuarial value of the cost-sharing provisions of the hospital and supplementary medical insurance parts of the medicare program which the plan covers in its enrollment charge. Beneficiaries could not be charged premiums

for covered services which include cost-sharing on non-covered types of expense such as the maternity expense factor in hospital care. If, however, the organization provides its enrollees services in addition to those covered under medicare, it must inform enrollees of the portion of the premium or other charges applicable to such additional services, and the portion applicable to medicare-covered services may not exceed the actuarial value of the cost-sharing provisions of the medicare program. Any portion of the actuarial value of deductibles and coinsurance which the HMO may assess at the time individual services are rendered may not exceed the actuarial value of medicare copayments. Under the House bill, the HMO could require a medicare beneficiary to accept and pay for coverage of services in addition to medicare benefits as a condition of enrollment. The committee believes that such a condition could place undue financial hardship on some medicare beneficiaries and has therefore modified the provision to make acceptance of a supplemental benefit package optional with the beneficiary. These requirements are intended to assure that beneficiaries enrolled with an HMO benefit fully from their medicare coverage and are, in effect, charged no more than the deductible and coinsurance amounts. This provision will also assure that beneficiaries who elect additional benefits are made aware of the exact cost of the supplemental coverage provided by the HMO.

Beneficiaries enrolled with a health maintenance organization who are dissatisfied with decisions of the organizations on benefit coverage would have the right to a hearing before the Secretary, in which the health maintenance organization would be an interested party, and to judicial review with respect to disputes involving amounts exceeding specified limits.

Beneficiaries could terminate their enrollment with a health maintenance organization and revert to regular coverage under the program in accordance with regulations. It is expected that, to the extent practicable, disenrollment would be patterned after the disenrollment procedure as is followed now with respect to disenrollment under the supplementary medical insurance program.

The committee also agrees with the concern reflected in the House bill that some organizations potentially qualified to contract on an incentive basis currently have enrollees who may desire to continue membership in the organization but who do not wish to agree to receive covered services only from that organization. Since it would seem inequitable to require such individuals to either disenroll immediately or involuntarily accept a limitation on their access to covered services, the committee has included a provision under which a health maintenance organization which has contracted on an incentive basis could continue through June 1976 to be reimbursed for covered care provided to beneficiaries who were members prior to July 1973 but who do not elect the option. For beneficiaries who do not elect the option, the usual capitation payment would be subject to additional actuarial adjustment to reflect projected use of out-of-plan services to the extent that such services would have been considered sufficiently reasonable and necessary to be provided by the HMO under the rules of that organization. Retroactive adjustment would be made at the end of the year to reflect actual expenses of the type otherwise reimbursable under the program incurred on behalf of such beneficiaries. Any savings or losses (and related apportionment thereof) would be determined

by comparing the HMO's actual incurred per capita costs, increased by a factor reflecting the costs of sufficiently reasonable and necessary out-of-plan services received by such beneficiaries, with the adjusted average per capita cost.

While the modifications and additional safeguards which have been included establish the potential for effective administration of the HMO provision, the committee nevertheless recognizes that use of the HMO approach to provision of health care services remains relatively unknown in many geographic areas. Accordingly, the committee believes that the Congress should be kept fully informed of program experience with the HMO provision so that appropriate modifications, as required, can be made as expeditiously as possible. It has, therefore, added a provision which would require the Secretary of Health, Education, and Welfare to report to the Congress within a reasonable period after the first annual reports by HMO's are received, and annually thereafter, in the HEW annual report, regarding experience with the HMO provision. Such reports should include general evaluation of the HMO provision in operation, and should specifically cover cost experience, quality of care considerations, numbers of beneficiaries who enroll, enrollment trends, and other relevant information including evaluation of the performance of the different types of HMO's. Enrollment trends are particularly significant as the medicare program would not benefit directly in a financial sense from the possible efficiencies of HMO's until a substantial number of medicare beneficiaries not presently enrolled choose to enroll in such organizations.

The committee expects that the Department will provide technical assistance, particularly with regard to matters concerning determination of proper actuarial rates, to assist States participating in the title XIX program to enter into contracts with HMO's (eligible as such under medicare) to provide services to medicaid eligibles where a State requests such assistance. The Federal Government would assume the cost of such technical and actuarial assistance as is necessary.

The provision would become effective with respect to services provided on or after July 1, 1973.

Repeal of Section 1902(d) of Medicaid

(Sec. 231 of the bill)

Under section 1902(d) of the medicaid law, a State may reduce the range, duration or frequency of the services it provides under its medicaid program, but it cannot reduce its aggregate expenditures for the State share of its medicaid program from 1 year to the next. Failure to comply with this requirement means ineligibility for Federal medicaid matching funds.

The House bill restricts the application of section 1902(d) to the mandatory health care services which all State medicaid programs must make available to eligible recipients. The House provision would permit a State to modify the scope and extent of such optional services as drugs, dental care and eyeglasses, but it could not reduce the amount of expenditures for the mandatory services.

The committee has been concerned about the effect of section 1902 (d) on States which may be faced with fiscal crises. Further, the committee believes that the maintenance of effort provision of section 1902(d) functions as a barrier to orderly development and operation of State programs, and that States are generally best able to determine the changing needs of their people.

The committee has therefore substituted for the House provision an amendment repealing section 1902(d). This action is consistent with the committee and Senate action on H.R. 17550 in 1970.

The committee does not expect that removal of the maintenance of effort requirement will result in large-scale cut-backs in benefits under the medicaid program, but it does believe that elimination of this provision will provide States with greater flexibility to design their programs to meet effectively the needs of their people for medical care within the fiscal constraints faced by given States from time-to-time.

Payments to States Under Medicaid for Development of Cost Determination Systems for State-Owned General Hospitals

(Sec. 235 of the bill)

Under present law, States are required to use methods of administration deemed necessary by the Secretary for efficient operation of the program. Despite this requirement, many States do not have effective claims administration or well-designed information storage and retrieval systems; nor do they possess the financial and technical resources to develop them if required to do so by the Secretary.

Section 235 as approved by the House authorizes 90 percent Federal matching for the cost necessary to design, develop, and install mechanized claims processing and information retrieval systems deemed necessary by the Secretary and 75 percent Federal matching for the operation of systems approved by the Secretary. States would not be eligible to receive this increased Federal support until they have developed the capacity to provide basic information to recipients on services paid for by the program, including the names of the providers, the dates on which services were furnished, and the amount of payment made. In addition, section 235 would provide 90 percent Federal matching during fiscal years 1972 and 1973 for the cost of design, development, or installation of cost determination systems for State-owned general hospitals, with total funds paid to all States under this clause not exceeding $150,000 in either year.

Although the committee acknowledges the obligation of the Federal Government to provide technical assistance to each State operating a medicaid program, it believes that the inducements of more efficient and effective administration of the program, and resulting reductions in program costs, should be sufficient to stimulate States to implement mechanized claims processing and information retrieval systems under the matching provisions of current law. Further, possible major changes in the nature and allocation of administrative responsibilities under medicaid during the next several years might quickly render such systems obsolete.

Therefore, the committee has deleted all of section 235 except for

the provision authorizing funds for cost-determination systems for State-owned general hospitals (such as that being undertaken by the State of Mississippi).

Utilization Review Requirements for Hospitals and Skilled Nursing Homes Under Medicaid and Maternal and Child Health Programs

(Sec. 237 of the bill)

Under medicare, each hospital and extended care facility is required to have a utilization review committee to review all long-stay cases as well as review, on a sample or other basis, admissions, durations of stay and professional services. The reasons for requiring hospitals and extended care facilities to have utilization review committees for medicare cases apply with equal validity to review of medicaid cases, but there is now no such requirement in the medicaid law. Under medicaid, the medical assistance unit of the State agency administering the medicaid program is responsible for all utilization review plans and activities under the medicaid program. The medical assistance unit may in lieu of establishing its own utilization review system delegate utilization review responsibilities for inpatient hospital and skilled nursing home care to the agency which monitors utilization review activities for such services under medicare.

The committee approved in H.R. 17550, and supports again in H.R. 1, the House provision which would require hospitals and skilled nursing homes participating in the medicaid or maternal and child health program to have cases reviewed by the same utilization review committee already reviewing medicare cases or, if one does not exist, by a review group which meets the standards established under medicare. However, the committee does not intend that where medicaid requires more stringent or comprehensive utilization review than does medicare, such requirements be reduced by virtue of operation of this section. Several States have developed and are applying utilization review procedures, different from the medicare utilization review committees, which have met with some success. The committee has, therefore, modified the House bill to provide that until such time as professional standards review organizations are operational in the States, the Secretary may waive the requirements of this section to permit States to substitute alternative utilization review systems where it can be demonstrated to his satisfaction that the alternative systems will be superior in effectiveness to the medicare requirement. To avoid duplication of review activity in such cases, the Secretary might also require usage where appropriate of the more effective medicaid review method for medicare patients as well, in lieu of the regular medicare procedure.

This provision would be effective January 1, 1973.

Program for Determining Qualifications for Certain Health Care Personnel

(Sec. 241 of the bill)

Under present law, the Secretary establishes various health and safety criteria as conditions for the participation of providers of service in the medicare program. In setting these standards it is necessary

to establish criteria for judging the professional competency and qualifications of key personnel in these health facilities. Medicare and medicaid regulations have relied heavily on formal training courses and professional society membership in judging professional competency.

In the report of this committee on the Social Security Amendments of 1967 (H.R. 12080), the committee agreed with the Secretary that appropriate criteria as prima facia evidence of competence are necessary. However, the committee expressed concern that reliance solely on specific formal education or training, or membership in private professional organizations might serve to disqualify people whose work experience and training might make them equally or better qualified than those who meet the existing requirements. The committee pointed out in 1967 that failure to make the fullest use of competent health personnel was of particular concern because of the shortage of such personnel.

In 1967, the committee recommended that the Secretary of Health, Education, and Welfare consult with appropriate professional health organizations and State health agencies and, to the extent feasible, explore, develop, and apply appropriate means—including testing procedures—for determining the proficiency of health care personnel otherwise disqualified or limited in responsibility under regulations of the Secretary. Moreover, the committee instructed the Secretary to encourage and assist programs designed to upgrade the capabilities of those not sufficiently skilled to qualify initially but who could perform satisfactorily and qualify on a proficiency basis with relatively little additional training.

However, despite that formal instruction and expectation of the committee the Department of Health, Education, and Welfare has since 1967 continued to rely almost entirely on formal training and professional society membership in measuring the qualifications of health care personnel. The Department has taken little or no action, except with respect to directors of clinical laboratories and to physical therapists in developing proficiency testing and training courses. The personnel problems which existed in 1967 and which the committee sought to alleviate, have been aggravated as a result of the Department's continued inaction.

The Medical Services Administration issued a ruling effective July 1, 1970, concerning licensed practical nurses in skilled nursing homes participating in medicaid. Nursing homes, according to the ruling, must have as charge nurses for each shift (other than the day shift which requires a registered nurse) a registered nurse or a licensed practical nurse, with a degree from a State-accredited school or its equivalent. There is an acute shortage of nursing personnel, and many hundreds of nursing homes have been covering some shifts with "waivered" practical nurses. These are practical nurses, who do not have the required formal training, and who, in many States, have been licensed on a waivered basis. Undoubtedly, a substantial proportion of these practical nurses have years of experience and are competent; obviously, other waivered practical nurses are not competent to serve as charge nurses.

As noted, the Department of Health, Education, and Welfare has taken no action since 1967, in developing proficiency testing or short-term supplemental training for these personnel, and consequently, many otherwise qualified nursing homes are being, or soon may be,

forced out of the program because of their inability to locate a registered nurse or a licensed practical nurse. Problems somewhat similar to those confronting waivered licensed practical nurses exist with respect to some therapists, medical technologists, and psychiatric technicians.

In view of this, the committee approved a provision in 1970, included in H.R. 17550 as passed by the Senate, which would require the Secretary to explore, develop, and apply appropriate means of determining the proficiency of health personnel disqualified or limited in responsibility under present regulations, and regularly report to the committee and to the Committee on Ways and Means of the House of Representatives concerning the Department's progress in this area.

Except for the time limit described, the House bill includes this provision. The committee has modified the House provision by again setting a time limit—December 31, 1977—beyond which determinations of proficiency would not apply with respect to persons initially licensed by a State or seeking initial qualification as a health care person. In addition, the committee specified that cytotechnologists were intended to be included among the types of health personnel to which the proficiency testing would apply.

The committee would emphasize again its concern that only qualified personnel be utilized in providing care under medicare and medicaid. However, appropriate methods and procedures are capable of being promptly developed and applied to determine qualifications and to upgrade skills to qualifying levels. The committee does not advocate "grandfathering" of poorly qualified health care personnel nor does it advocate usage of arbitrary and inflexible cut-off standards of qualification which rule out of program participation many competent personnel.

Reimbursement Appeals by Providers of Services

(Sec. 243 of the bill)

Under present law a fiscal intermediary determines the amount of reasonable cost to be paid to a provider of services. There is no specific legislative provision for an appeal by the provider of the intermediary's final reasonable cost determinations. Although the Social Security Administration has instituted certain administrative procedures to assist providers and intermediaries to reach reasonable and mutually satisfactory settlements of disputed reimbursement items, the committee believes that it is desirable to prescribe in law a specific appeals procedure for disputed final settlements applying to reasonable cost determinations. This procedure does not apply to questions of coverage or disputes involving individual beneficiary claims.

The committee has therefore approved, with modifications, a provision in the House bill which would provide for the establishment of the Provider Reimbursement Review Board. The Board would be composed of five members, knowledgeable in the field of health care reimbursement, appointed by the Secretary of Health, Education, and Welfare. At least one member of the Board would be a certified public accountant. The Secretary would select two of the members from qualified and acceptable nominees of the providers. The Provider Reimbursement Review Board would be authorized to make rules and

establish procedures necessary to its operation in accordance with regulations established by the Secretary of Health, Education, and Welfare.

Under the House bill, any provider of services which has filed a timely cost report may appeal an adverse final decision of the fiscal intermediary to the Board where the amount at issue is $10,000 or more. The appeal must be filed within 180 days after notice of the fiscal intermediary's final determination. The committee modified this portion of the provision by including two additional situations which could serve as a basis for provider appeals. The first provision would enable groups of providers to appeal adverse final decisions of the fiscal intermediary to the Board where the amount at issue aggregates $10,000 or more. The second modification enables any provider which believes that its fiscal intermediary has failed to make a timely cost determination on its annual cost report, if such report is susbtantially in proper order, or a timely determination on an acceptable supplemental filing where the initial filing was deficient, to appeal to the Board where the amount involved is $10,000 or more. Implementation of the intermediary determinations would not be held in abeyance pending the Board's decision.

The provider shall have the right to reasonable notice as to the time and place of hearing and reasonable opportunity to appear at the hearing. It may be represented by counsel and introduce reasonable and pertinent evidence to supplement or contradict the evidence considered by the fiscal intermediary. Reasonable opportunity to examine and cross-examine witnesses shall be provided. All decisions by the Board shall be based upon the record made at such hearing which may include any evidence submitted by the Department. Such evidence shall include the evidence or record considered by the intermediary. Based upon examination of all of the evidence, such Board may find in whole or in part for the provider or the Government (including a finding based upon the evidence before it that the provider or Government owes sums in addition to the amount raised in the appeal).

A decision of the Provider Reimbursement Review Board would be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses or modifies the Board's decision adversely to the provider. In any case where such reversal or modification occurs, the provider of services would have the right to obtain a review of such a decision by the United States District Court for the district in which it is located or in the United States District Court for the District of Columbia, as an aggrieved party under the Administrative Procedures Act, notwithstanding any other provision in section 205 of the Social Security Act.

The amendment would become effective with respect to accounting periods beginning on or after July 1, 1972.

Physical Therapy and Other Therapy Services Under Medicare

(Sec. 251 of the bill)

Under present law, physical therapy is covered as an inpatient hospital service, an inpatient extended care service, a home health service, and a service incident to physicians' services. Physical therapy is also covered when furnished under prescribed conditions by a participating

hospital, extended care facility, home health agency, clinic, rehabilitation agency, or public health agency to outpatients. The physical therapist may either be an employee of the participating facility or he may be self-employed and furnish his services under arrangements with and under the supervision of the facility.

The House bill would provide for coverage, under the supplementary medical insurance program, of up to $100 per calendar year of physical therapy services furnished by a licensed physical therapist in his office or in the patient's home under a physician's plan. Reimbursement for the reasonable charges for the covered services rendered by the physical therapist would be made either to the beneficiary or, on assignment, directly to the physical therapist.

The committee has been advised by the Department of Health, Education, and Welfare that the House provision would be difficult to administer in terms of assuring the provision of appropriate services, or of effectively enforcing the health, safety, and quality safeguards embodied in present law, since physical therapists would be furnishing services outside the controlled environment of an institutional setting or responsibility. Moreover, this provision would compound the already costly and troublesome problem of restraining overutilization and inappropriate utilization of physical therapy services. The committee agrees with the Department that at the present time whatever advantage might accrue to beneficiaries from increased availability of services would be at the expense of higher benefit and administrative costs. For these reasons, the committee has deleted this special $100 feature of the House bill.

The committee is concerned about the few cases under present law where an inpatient exhausts his inpatient benefits or where he is otherwise ineligible for hospital insurance inpatient benefits and can continue to receive supplementary medical insurance reimbursement for physical therapy treatment only if the hospital or extended care facility is able to arrange for another participating facility to furnish the physical therapy treatment as an outpatient service. The House bill would authorize a hospital or extended care facility to furnish outpatient physical therapy services to its inpatients in the above categories. The committee concurs with the House bill on this provision and the effective date for this subsection would make the provision effective for services furnished after enactment of the bill.

The House bill also includes a provision for controlling program expenditures and for preventing abuses. Under this provision payment for the reasonable cost of physical, occupational, and speech therapy services, or the services of other health specialists, furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency under arrangements with others to supply such services, may not exceed an amount equivalent to the salary and other costs which would reasonably have been payable if the services had been performed in an employment relationship, plus the cost of such expenses an individual not working as an employee might have, such as maintaining an office, traveltime and expense, and similar costs.

The committee concurs with the House amendment, which reflects the changes made by the committee during its consideration of H.R. 17550, the Social Security Amendments of 1970. The committee

expects—as does the Committee on Ways and Means—that the Secretary will, in establishing the criteria for determining the reasonable cost of such services, consult with the professions directly affected and give thorough consideration to procedures used in other public and private plans that may be local, regional, or national in scope. Further, the committee expects that the Secretary will establish salary equivalents by appropriate geographic areas (including, where appropriate and feasible rural and urban distinctions) and that such amounts will be set at the 75th percentile of the range of salaries paid in the area to therapists working full-time in an employment relationship, with such additional or adjusted allowance for salaries paid to therapists whose duties are supervisory or administrative in nature, as the Secretary finds to be appropriate. To the extent feasible, timely, and accurate, salary data compiled by the Bureau of Labor Statistics would be used in determining the 75th percentile level of salaries in an area. If a provider requires the services of a physical therapist on a limited part-time basis or only to perform intermittent services the Secretary may make payment on the basis of a reasonable rate per unit of service greater per unit of time than salary equivalent amounts where he finds that such greater payment is in the aggregate less than would have resulted if the provider employed a therapist on a full or part-time salaried basis.

The above provision would be effective with respect to accounting periods beginning on or after January 1, 1973.

Collection of Supplementary Medical Insurance Premiums From Individuals Entitled to Both Social Security and Railroad Retirement Benefits

(Sec. 263 of the bill)

Under present law, the responsibility for collecting supplementary medical insurance premiums for enrollees entitled to both railroad retirement benefits and social security benefits is vested in either the Social Security Administration or the Railroad Retirement Board, depending upon the circumstances of entitlement at the time of enrollment. This arrangement requires an administrative procedure under which persons so entitled can enroll in the supplementary medical insurance program with either agency. The result has been that some individuals (because all the facts are not made known at the time of enrollment) are enrolled twice and have two different identifying numbers; others are enrolled by the Social Security Administration and not enrolled by the Railroad Retirement Board, or vice versa, and thus may have two medicare cards—one showing entitlement to benefits under part A only and the other showing entitlement to benefits under both parts A and B. Such discrepancies, even though ultimately corrected, are a source of confusion to beneficiaries and a cause of unnecessary administrative expense.

Also, the processing of medical insurance claims is established so as to require that all claims submitted by or on behalf of railroad beneficiaries be handled by a single carrier, presently the Travelers Insurance Company. Because the account numbers assigned to railroad

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beneficiaries who enroll with the Social Security Administration are not identified as applying to railroad beneficiaries (because the beneficiary does not make this known), many railroad beneficiary claims are submitted to other carriers and require rerouting to Travelers Insurance Company. This is expensive and a cause of delay in making payments.

The committee agrees with the provision in the House bill which provides that the Railroad Retirement Board shall be responsible for collection of supplementary medical insurance premiums for all enrollees who are entitled under that program. This change will eliminate the confusion, payment delay, and administrative expense deriving from the related provisions of present law.

Under the House bill the Railroad Retirement Board would be authorized to contract with a carrier or carriers for purposes of servicing its beneficiaries with respect to part B benefits, an arrangement presently in effect as a result of the Commissioner of Social Security having delegated his authority to do this to the Railroad Retirement Board. However, in the interest of program efficiency, economy, and consistency of administration in an area, the committee bill would delete that part of the provision which grants the Railroad Retirement Board authority to choose the carrier for part B benefits for its beneficiaries so that the Secretary of Health, Education, and Welfare would continue to have this authority.

This provision would be effective for premiums becoming due and payable after the fourth month after the month of enactment.

Waiver of Requirement of Registered Professional Nurses in Skilled Nursing Facilities in Rural Areas

(Sec. 267 of the bill)

Under current law, a skilled nursing facility certified to participate in the medicaid program is required to maintain an organized nursing service under the direction of a registered professional nurse who is employed full time. The law requires the nursing service to be composed of sufficient nursing and auxiliary personnel to provide adequate and properly supervised nursing services to patients during all hours of each day and all days of each week. The House was concerned that this requirement posed special problems for skilled nursing facilities in rural areas where there is inadequate availability of registered nurses to staff a facility and therefore authorized a waiver of the requirement for a full-time registered nurse in rural skilled nursing homes.

While the committee recognizes the difficulty faced by many rural skilled nursing facilities in obtaining necessary nursing staff, the committee also believes it necessary to safeguard the patient whose nursing needs warrant continuing care by a registered nurse, such as those patients requiring administration of potent injectable and intravenous medications or medicinal gases on a regular basis, maintenance of tracheotomies or gastrotomies, tubal feeding, etc.

In recognition of the staffing difficulties of the rural skilled nursing facilities, the committee amendment provides that, to the extent

that law or regulation requires the presence of a registered nurse on one full-shift 7 days a week, a special waiver of the nursing requirement for these facilities may be granted provided that a registered nurse is absent from the facility for not more than two day-shifts (if the facility employs one full-time registered nurse) and the facility is making good faith efforts to obtain another on a part-time basis. The American Nurses Association has indicated that State nurses' associations would willingly cooperate in efforts to secure necessary nursing personnel; the committee expects that, to the extent such cooperation is extended it will be utilized toward alleviating a skilled nursing shortage in a facility.

Additionally, to protect those patients who may need daily skilled nursing care, this special waiver may be granted only if (1) the facility is caring only for patients whose physicians have indicated (in written form on order sheet and admission note) that they could go without a registered nurse's services for a 48-hour period or (2) if the facility has any patients for whom physicians have indicated a need for daily skilled nursing services, the facility has made arrangements for a registered nurse or a physician to spend such time as is necessary at the facility to provide the skilled nursing services required by patients on the uncovered day.

Coverage of Chiropractic Services Under Medicare

(Sec. 273 of the bill)

Under the House bill, the Secretary would be required to conduct a study of chiropractic services covered under State plans approved under title XIX. The study would determine whether and to what extent chiropractic services should be covered under the supplementary medical insurance program of title XVIII, giving particular attention to the limitations which should be placed on such coverage and on the amounts to be paid for whatever services might be furnished. The Committee on Finance believes, however, that further study of chiropractic services is not required to support coverage of the services of chiropractors under the supplementary medical insurance program.

In providing coverage for the services of chiropractors, the committee recognizes the need for controls on the quality, cost, and utilization of such services. Accordingly, the committee bill would broaden the definition of the term "physician" in title XVIII to include a licensed chiropractor who also meets uniform minimum standards to be promulgated by the Secretary. The committee believes that at least uniform minimum standards of the following kinds should underlie licensure: satisfactory evidence of preliminary education equal to the requirements for graduation from an accredited high school or other secondary school; a diploma issued by a college of chiropractic approved by the State's chiropractic examiners and where the practitioner has satisfied the requirements for graduation including the completion of a course of study covering a period of not less than three school years of six months each year in actual continuous attendance covering adequate courses of study in the subjects of anatomy, physiology, symptomatology and diagnosis, hygiene and sanitation, chem-

istry, histology, pathology, and principles and practice of chiropractic, including clinical instruction in vertebral palpation, nerve tracing and adjusting; and passage of an examination prescribed by the State's chiropractic examiners covering said subjects. Moreover, the committee does not intend that the practice of operative surgery, osteopathy, or administering or prescription of any drug or medicine included in materia medica should be covered by the practice of chiropractic. Such standards would also be applicable to coverage of chiropractic services under medicaid.

The services furnished by chiropractors would be covered under the program as "physicians' services," but only with respect to treatment of the spine by means of manual manipulation which the chiropractor is legally authorized to perform. As with other program benefits, the committee is aware of the possible overutilization of chiropractic services, and expects that the Secretary will issue guidelines to medicare carriers for use in review of bills for such services, to assure proper usage of the benefit.

The amendment would become effective with respect to services provided on or after July 1, 1973.

3. NEW PROVISIONS ADDED BY THE FINANCE COMMITTEE

Professional Standards Review

(Sec. 249F of the Bill)

According to recent estimates the costs of the medicare hospital insurance program will overrun the estimates made in 1967, by some $240 billion over a 25-year period. The monthly premium costs for part B of medicare—doctors' bills—rose from a total of $6 monthly per person on July 1, 1966, to $11.60 per person on July 1, 1972. Medicaid costs are also rising at precipitous rates.

The rapidly increasing costs of these programs are attributable to two factors. One of these is an increase in the unit cost of services such as physicians' visits, surgical procedures, and hospital days. H.R. 1, as reported, contains a number of desirable provisions which the committee believes should help to moderate these unit costs.

The second factor which is responsible for the increase in the costs of the medicare and medicaid programs is an increase in the number of services provided to beneficiaries. The Committee on Finance has, for several years, focused its attention on methods of assuring proper utilization of these services. That utilization controls are particularly important was extensively revealed in hearings conducted by the subcommittee on medicare and medicaid. Witnesses testified that a significant proportion of the health services provided under medicare and medicaid are probably not medically necessary. In view of the per diem costs of hospital and nursing facility care, and the costs of medical and surgical procedures, the economic impact of this overutilization becomes extremely significant. Aside from the economic impact the committee is most concerned about the effect of overutilization on the health of the aged and the poor. Unnecessary hospitalization and unnecessary surgery are not consistent with proper health care.

Review of Present Utilization Controls

The committee has found that present utilization review requirements and activities are not adequate.

Under present law, utilization review by physician staff committees in hospitals and extended care facilities and claims review by medicare carriers and intermediaries are required. These processes have a number of inherent defects. Review activities are not coordinated between medicare and medicaid. Present processes do not provide for an integrated review of all covered institutional and noninstitutional services which a beneficiary may receive. The reviews are not based upon adequately and professionally developed norms of care. Additionally, there is insufficient professional participation in, and support of, claims review by carriers and intermediaries and consequently there is only limited acceptance of their review activities. With respect to the quality of care provided, only institutional services are subject to quality control under medicare, and then only indirectly through the application of conditions of participation.

Under present law, each hospital and extended care facility must have a utilization review plan covering services provided to medicare patients which provides for review, on a sample or other basis, of admissions, duration of stays, and the professional services furnished. The review is to include consideration as to the medical necessity of the services and the efficient use of health facilities and services. The utilization review is undertaken by either (1) a group, including at least two physicians, organized within the institution or (2) a group (including at least two physicans) organized by a local medical society or other group approved by the Secretary of Health, Education, and Welfare. The statute provides also that the utilization review group must be organized as in (2) above, if the institution is small or for such other good reasons as may be included in regulations. The utilization review group must also review long-stay cases and inform those concerned (including the attending physician) when it determines that hospitalization or extended care is no longer medically necessary.

The Finance Committee and the Ways and Means Committee stressed in 1965 that these requirements, if effectively carried out, would discourage improper and unnecessary utilization. The Finance Committee Report (S. Rept. 404, pt. I, 89th Cong., p. 47) stated:

> The committee is particularly concerned that the utilization and review function is carried out in a manner which protects the patients while at the same time making certain that they remain in the hospital only so long as is necessary, and that every effort be made to move them from the hospital to other facilities which can provide less expensive, but equal, care to meet their current medical needs.

The detailed information which the committee has collected and developed as well as internal reports of the Social Security Administration indicate clearly that utilization review activities have, generally speaking, been of a token nature and ineffective as a curb to unnecessary use of institutional care and services. Utilization review in medicare can be characterized as more form than substance. The pres-

ent situation has been aptly described by a State medical society in these words:

> Where hospital beds are in short supply, utilization review is fully effective. Where there is no pressure on the hospital beds, utilization review is less intense and often token.

The current statute places upon the intermediary as well as the State health agency responsibility for assuring that participating hospitals and extended-care facilities effectively perform utilization review.

Available data indicate that in many cases intermediaries have not been performing these functions satisfactorily despite the fact that the Secretary may not, under the law, make agreements with an intermediary who is unwilling, or unable, to assist providers of services with utilization review functions.

Apart from the problems experienced in connection with their determinations of "reasonable" charges, the performance of the carriers responsible for payment for physicians' services under medicare has also varied widely in terms of evaluating the medical necessity and appropriateness of such services. Moreover, ever since medicare began, physicians have expressed resentment that their medical determinations are challenged by insurance company personnel. The committee has concluded that the present system of assuring proper utilization of institutional and physicians' services is basically inadequate. The blame must be shared between failings in the statutory requirements and the willingness and capacity of those responsible for implementing what is required by present law.

There is no question, however, that the Government has a responsibility to establish mechanisms capable of assuring effective utilization review. Its responsibility is to the millions of persons dependent upon medicare and medicaid, to the taxpayers who bear the burden of billions of dollars in annual program costs, and to the health care system.

In light of the shortcomings outlined above, the committee believes that the critically important utilization review process must be restructured and made more effective through substantially increased professional participation.

The committee believes that the review process should be based upon the premise that only physicians are, in general, qualified to judge whether services ordered by other physicians are necessary. The committee is aware of increasing instances of criticism directed at the use of insurance company personnel and Government employees in reviewing the medical necessity of services.

The committee generally agrees with the principles of "peer review" enunciated in the report of the President's Health Manpower Commission, issued in November 1967. That report stated:

> Peer review should be performed at the local level with professional societies acting as sponsors and supervisors.
>
> Assurance must be provided that the evaluation groups perform their tasks in an impartial and effective manner.
>
> Emphasis should be placed on assuring high quality of performance and on discovering and preventing unsatisfactory performance.

> The more objective the quality evaluation procedures, the more effective the review bodies can be. To enable greater objectivity, there should be a substantial program of research to develop improved criteria for evaluation, data collection methods, and techniques of analysis.[1]

The committee has therefore included an amendment, as it did in H.R. 17550, which authorizes the establishment of independent professional standards review organizations (PSRO's) by means of which practicing physicians would assume responsibility for reviewing the appropriateness and quality of the services provided under medicare and medicaid.

The Committee Provision

The committee has provided for a review mechanism through which practicing physicians can assume full responsibility for reviewing the utilization of services. The committee's review mechanism at the same time contains numerous safeguards intended to fully protect the public interest.

The committee provision would establish broadly based review organizations with responsibility for the review of both institutional and outpatient services, as opposed to the present fragmented review responsibilities.

The new review organizations would be large enough to take full advantage of rapidly evolving computer technology, and to minimize the inherent conflicts of interest which have been partially responsible for the failure of the smaller institutionally based review organizations. The review process would be made more sophisticated through the use of professionally developed regional norms of diagnosis and care as guidelines for review activities, as opposed to the present usage of arbitrarily determined checkpoints. The present review process, without such norms, becomes a long series of episodic case-by-case analyses on a subjective basis which fail to take into account in a systematic fashion the experience gained through past reviews or to sufficiently emphasize general findings about the pattern of care provided. The committee believes that the goals of the review process can be better achieved through the use of norms which reflect prior review experience.

The committee's bill provides specifically for the establishment of independent professional standards review organizations (PSRO's) formed by organizations representing substantial numbers of practicing physicians in local areas to assume responsibility for the review of service (but not payments) provided through the medicare and medicaid programs.

Recognizing the problem, on their own, a number of medical societies and other health care organizations have already sponsored similar types of mechanisms for purposes of undertaking unified and coordinated review of the total range of health care provided patients. Additional medical societies are proceeding to set up such organizations.

In reaffirming its conviction that the establishment of PSRO's should result in important improvements to the medicare and medicaid programs, the committee has taken particular note of the progress which has been made by a number of prototype review organizations

[1] Report of the Health Manpower Commission, November 1967, p. 48.

across the country. Experience by these organizations has provided the committee with convincing evidence that peer review can—and should—be implemented on an operational, rather than merely an experimental basis.

The committee expects that in developing the policies and regulations implementing the PSRO provision, the Secretary will seek the advice and counsel of physicians and administrators connected with existing successful review organizations.

However, in most parts of the country, new organizations would need to be developed.

The committee would stress that physicians—preferably through organizations sponsored by their local associations—should assume responsibility for the professional review activities. Medicine, as a profession, should accept the task of advising the individual physician where his pattern of practice indicates that he is overutilizing hospital or nursing home services, overtreating his patients, or performing unnecessary surgery.

It is preferable and appropriate that organizations of professionals undertake review of members of their profession rather than for Government to assume that role. The inquiry of the committee into medicare and medicaid indicates that Government is ill equipped to assure adequate utilization review. Indeed, in the committee's opinion, Government should not have to review medical determinations unless the medical profession evidences an unwillingness to properly assume the task.

But, the committee does not intend any abdication of public responsibility or accountability in recommending the professional standards review organizations approach. While persuaded that comprehensive review through a unified mechanism is necessary and that it should be done through usage, wherever possible and wherever feasible, of medical organizations, the committee would not preclude other arrangements being made by the Secretary where medical organizations are unwilling or unable to assume the required work or where such organizations function not as an effective professional effort to assure proper utilization and quality of care but rather as a token buffer designed to create an illusion of professional concern.

In a number of areas of the country, carriers and intermediaries—even though their activity is limited to restrospective review—are doing a reasonably effective job of controlling unnecessary utilization of health care services. Such efforts should not be terminated in any area until such time as a PSRO has satisfactorily demonstrated the willingness, operational capacity, and performance to effectively supplant and improve upon existing review work. Even where the PSRO becomes the paramount review organization, the existing review, if it is efficient and effective, should not be dismantled, if the PSRO can benefit by utilizing its experience and services.

Establishment of PSRO's

The amendment requires the Secretary, following consultation with national, State and local, public and private medical care organizations, and medical societies, to tentatively designate PSRO areas throughout the country by January 1, 1974. In smaller or more sparsely populated States, the designations would probably be on a

statewide basis. Each area, defined in geographic or medical service area terms, would generally include a minimum of 300 practicing physicians—in most cases substantially more than that number. Because of the minimum number of physicians required—intended to assure broad, diverse, and objective representation—it is expected that there will be many multicounty PSRO areas.

Tentative area designations could be modified if, as the system was placed into operation, changes seemed desirable. Area designations would also take into consideration the need to assure a reasonably coordinated administrative arrangement among PSRO's and the various medicare and medicaid administrative mechanisms in a State or area. The Secretary would provide prototype plans of organization and operation to prospective PSRO's in each area. The prototypes would be developed in consultation with proposed PSRO's and with various organizations presently operating comprehensive review mechanisms as well as national, State and local, private and public, health organizations.

It should be emphasized that in recommending operational, rather than experimental authority, it is recognized that the successful development of professional review organizations can encompass a variety of prototypes and that changes in technology can be expected to result in continued modifications in procedures, and that much remains to be done in the area of the development and refinement of professional norms. It is believed, though, that the proposal can be implemented within an overall framework of innovation and flexibility. The committee believes, further, that only a full implementation effort will provide the impetus needed to establish effective and equitable comprehensive professional review throughout the Nation.

Priority in designation as a PSRO would be given to organizations established at local levels representing substantial numbers of practicing physicians who are willing and believed capable of progressively assuming responsibility for overall continuing review of institutional and outpatient care and services. Local sponsorship and operation should help engender confidence in the familiarity of the review group with norms of medical practice in the area as well as in their knowledge of available health care resources and facilities. Furthermore, to the extent that review is employed today, it is usually at the local level. To be approved, a PSRO applicant must provide for the broadest possible involvement, as reviewers on a rotating basis, of physicians engaged in all types of practice in an area such as solo, group, hospital, medical school, and so forth.

Participation in a PSRO would be voluntary and open to every physician in the area. Existing organizations of physicians should be encouraged to take the lead in urging all their members to participate and no physician could be barred from participation because he is or is not a member of any organized medical group or be required to join any such group or pay dues or their equivalent for the privilege of becoming a member or officer of any PSRO nor should there be any discrimination in assignments to perform PSRO duties based on membership or nonmembership in any such organized group of physicians.

Physician organizations or groupings would be completely free to undertake or to decline assumption of the responsibilities of organizing a PSRO. If they decline, the Secretary would be empowered to seek alternative applicants from among other medical organizations, State

and local health departments, medical schools, and failing all else, carriers and intermediaries or other health insurers. In no case, however, could any organization be designated as a PSRO which did not have professional medical competence. And, in no case could any final adverse determinations by a PSRO with respect to the conduct or provision of care by a physician be made by anyone except another qualified physician.

PSRO physicians engaged in the review of the medical necessity for hospital care and justification of need for continued hospital care must be active hospital staff members. The purpose here is to assure that only doctors knowledgeable in the provision and practice of hospital care will review such care. To the extent feasible, it is intended that a physician not be involved in decisionmaking in the review of care for the PSRO which was provided in a hospital where he has active staff privileges (except to the extent of his involvement with "in-house" review acceptable to the PSRO).

The committee expects that the Secretary will provide every possible assistance to the PSRO's. The Department would be required to develop prototype review plans and would be expected to provide assistance and encouragement in the development of acceptable review plans. Proposals submitted to the Secretary by prospective PSRO's would be made available, on request, to appropriate concerned organizations and individuals who, in turn, would be free to submit to the Secretary such comments on the proposal as might assist his evaluation of the prospective PSRO. The Department would also be required to develop the capacity to evaluate the potential of review plans proposed by organizations throughout the country, and with the assistance and advice of the National Professional Standards Review Council, to monitor on a regular and continuing basis the performance of the organizations selected through the use of statistical comparisons and other means of evaluation.

The committee recognizes that proper administration of this provision will involve substantial administrative effort and expense. However, over the long run, the PSRO provision, properly implemented, should result in substantial reductions in program costs and improved quality of care. The Secretary is expected to take such administrative steps and provide all necessary assistance and cooperation to assure that no PSRO fails because it does not have access to the means or information required to perform adequately.

Conditional Status of PSRO's

A qualified PSRO applicant would be approved on a conditional basis for a period not to exceed 2 years during which it would develop and expand its review activities and capacity. Contracts may be terminated upon 90 days' notice by either the PSRO or the Secretary. During the conditional period, existing medicare and medicaid review operations would also continue so as to provide backup and standby capacity in the event a PSRO encounters difficulties or is terminated. At the end of the conditional period, where the PSRO has satisfactorily demonstrated its effectiveness in review, the Secretary would have authority and would be expected to waive any other professional review requirements, in whole or part, imposed under the law and regulations.

Medicare and medicaid claims-paying agencies would be expected to abide by final decisions of the PSRO during this trial period. Placing reliance on the PSRO decision during the trial period is necessary to permit an accurate appraisal of the effectiveness with which the conditionally approved PSRO's could be expected to exercise the review function in the absence of concurrent review by others.

As noted, once an organization is accepted as a PSRO the Secretary would regularly evaluate its performance using statistical comparison and other means of evaluation including the findings and recommendations of the statewide and national professional standards review councils established under the amendment. Where performance of an organization was determined to be unsatisfactory, and timely efforts to bring about its improvement failed, the Secretary could terminate its participation after appropriate notice and opportunity for administrative hearing. A finding, for example, that one PSRO was accepting without question substantial numbers of requests which other apparently well-run PSRO's were generally investigating and denying would be expected to result in termination of the agreement with the former PSRO unless the situation is justified by factors related to medical necessity or unless reasonable action to correct the problem is undertaken.

The committee anticipates that PSRO's will function in effective and dedicated fashion under the guidance of concerned physicians. In instances where there might be only nominal or halfhearted performance, it would be expected that necessary remedial action would be promptly taken through the initiative of the medical profession and, failing that, by the Secretary.

If the Secretary found it necessary to replace a review organization, as a first step he would consult with other review organizations in the State involved as well as with the State medical society to determine whether another local organization or an organization sponsored by the State society itself was willing and capable of undertaking review responsibility in the geographic area concerned. In the event that such was not the case, he could then contract with State or local health departments or employ other suitable professional means of assuring the necessary review activity in the area.

Responsibilities of a PSRO

A PSRO would have the responsibility of determining—for purposes of eligibility for medicare and medicaid reimbursement—whether care and services provided were: first, medically necessary, and second, provided in accordance with professional standards. Additionally, the PSRO where medically appropriate, would encourage the attending physician to utilize less costly alternative sites and modes of treatment. The PSRO would not be involved with questions concerning the reasonableness of charges or costs or methods of payment nor would it be concerned with internal questions relating to matters of managerial efficiency in hospitals or nursing homes except to the extent that such questions substantially affect patterns of utilization. The PSRO's responsibilities are confined to evaluating the appropriateness of medical determinations so that medicare and medicaid payments will be made

only for medically necessary services which are provided in accordance with professional standards of care.

The local PSRO would be primarily responsible for review of all medicare and medicaid services rendered or ordered by physicians in its area. The purpose of the provision is to establish a unified review mechanism for all health care services under the aegis of the principal element in the health care equation, the physician. Christian Science practice, however, would not be encompassed in the overall review and review arrangements required of a PSRO.

In carrying out its responsibilities the PSRO would be required to regularly review provider and practitioner profiles of care and service (that is, the patterns of services delivered to medicare and medicaid beneficiaries by individual health care practitioners and institutions) and other data to evaluate the necessity, quality, and appropriateness of services for which payment may be made under the medicare and medicaid programs.

The PSRO would be expected to analyze the pattern of services rendered or ordered by individual practitioners and providers and to concentrate its attention on situations in which unnecessary, substandard, or inappropriate services seem most likely to exist or occur. Emphasis in review efforts would be related to the results expected to be achieved by these efforts so that the net advantage from the review time would be maximized.

A PSRO would have authority to approve the medical necessity of all elective hospital admissions in advance—solely for the purpose of determining whether medicare or medicaid will pay for the care. The PSRO would also be required to acknowledge and accept, in whole or in part, an individual hospital's own review of admissions and need for continued care, on a hospital-by-hospital basis, where it has determined that a hospital's "in-house" review is effective. It is expected that where such "in-house" review is effective this authority would be exercised by the PSRO. Similarly, a PSRO would be required to acknowledge and accept for its purposes, review activities of other medical facilities and organizations, including those internal review activities of comprehensive prepaid group practice programs such as the Kaiser Health plans and the Health Insurance Plan (H.I.P.) in New York to the extent such review activities are effective. In issuing regulations to assure orderly operation of this procedure of evaluating in-house review the Secretary would be expected to incorporate reasonable appeals procedures to avoid any non-professional prejudice or bias by the PSRO in acceptance or rejection of in-house review. In order to assure the broadest possible participation in PSRO activities by physicians in an area, internal review activities will not be accepted by a PSRO where the physicians of the institution or medical organization concerned do not participate in the overall review activities conducted by the PSRO. Thus an institution or medical organization which is carrying out effective review would bring its desirable expertise to the benefit of the entire community, to the extent that the PSRO finds those review activities and experience effectively assist in fulfilling its overall responsibilities.

The purpose here is to build upon and encourage improvement in existing systems of review to the extent those systems are capable of

assisting in fulfilling the overall responsibilities of a PSRO. Thus effective review mechanisms would be recognized and encouraged by the PSRO. Of course, PSRO's would use this authority carefully. Indiscriminate acceptance of hospital and other review activities would undoubtedly be reflected in an overall poor performance rating when a PSRO was measured against other PSRO's operating in careful fashion. A poor rating could, in turn, lead to termination and replacement of the negligent PSRO. Where provision of services was disapproved by the PSRO, payment for the services could not be made under medicare or medicaid (unless the disapproval was reversed in the course of reconsideration, hearing, or court review). In case of advance review the institution and the patient alike would know in advance whether medicare will pay for the health care services being contemplated, although denial of certification for admission would not bar admission of any patient to an institution if his physician desires to admit him and if the institution accepts his admission. In this regard, medicare parallels private health insurance where a private policy issuer might determine that the care proposed or rendered was not reimbursable under the terms of the policy.

Where advance approval by the review organizations for institutional admission was required and provision of the services was approved by the PSRO, or where and to the extent the PSRO accepted "in-house" review, such approval would provide the basis for a presumption of medical necessity for purposes of medicare and medicaid benefit payments. However, advance approval of institutional admission would not preclude a retroactive finding that ancillary services (not specifically approved in advance) provided during the covered stay were excessive.

The PSRO, where it has not accepted in-house review in a given hospital as adequate, would be responsible for reviewing attending physicians' certifications of need for continued hospital care beyond professionally determined regional norms directly related to patients' age and diagnoses, using criteria such as the types of data developed by the Commission on Professional and Hospital Activities, which is sponsored by the American Hospital Association, the American College of Physicians, and the American College of Surgeons. It is expected that such certification would generally be required not later than the point where 50 percent of patients with similar diagnoses and in the same age groups have usually been discharged. However, it is recognized that there are situations in which such stays for certain diagnoses may be quite short in duration. In such situations the PSRO might decide against requiring certification at or before the expiration of the period of usual lengths of stay on the grounds that the certification would be unproductive; for example, when the usual duration of stay is two days or less. Certification on the first day of stay might yield no significant advantage in the review process. This professionally determined time of certification of need for continued care is a logical checkpoint for the attending physician and is not to be construed as a barrier to further necessary hospital care. Neither should the use of norms as checkpoints, nor any other activity of the PSRO, be used to stifle innovative medical practice or procedures. The intent is not conformism in medical practice—the objective is reasonableness.

PSRO disapproval of the medical necessity for continued hospital care beyond the norm for that diagnosis will not mean that the physician must discharge his patient. The physician's authority to decide the date of discharge as well as whether his patient should be admitted in the first place cannot be and are not taken from him by the PSRO. The review responsibility of the PSRO is to determine whether the care should be paid for by medicare and medicaid. By making this determination in advance, the patient, the institution, and the physician will all be forewarned of the desirability of making alternative plans for providing care or financing the care being contemplated.

Similarly, as feasible, out-of-institution norms would be developed and utilized based upon patterns of actual and proper practice by physicians. Such norms are available in many areas to an extent today. It is recognized that continuing efforts will need to be made to improve the scope and comprehensiveness of such norms.

Operation of a PSRO

It is expected that a PSRO would operate in a manner which conserves and maximizes the productivity of physician review time without unduly imposing on his principal function, the provision of health care services to his own patients. One way to conserve physician review time is through automated screening of claims by computers and other devices used in the claims process carried out under review specifications and parameters set forth by the PSRO. Another way to conserve physician time would be through the use of other qualified personnel such as registered nurses who could, under the direction and control of PSRO physicians, aid in assuring effective and timely review. And as already pointed out, a third is by utilizing the services of active and conscientious utilization review committees in hospitals and in local medical organizations.

It is expected that the Secretary will develop necessary procedures for coordination between medicaid agencies, medicare carriers and intermediaries and the PSRO's. To the extent that profiles are presently maintained by State agencies, carriers and intermediaries, these would be made available to the PSRO's. Following completion of the conditional period of PSRO designation the Secretary would be authorized to waive any control or review activity required by law which he determines to be unnecessary in view of the review and control activities assumed by and effectively performed by a PSRO. Thus, the PSRO activity would be fitted into the medicare-medicaid process with an eye to efficiency in the system. When a federally financed system of operation of a PSRO is developed, whether directly by the PSRO or by contract, that system would be made available without charge for use by other PSRO's.

Existing medical organizations, such as the San Joaquin and Sacramento Medical Foundations in California, and others have developed patient and practitioner profile forms and approval certification and other review methods which may provide the bases for development of uniform data gathering and review procedures capable of being employed in many areas of the Nation. The committee expects that the Secretary, in conjunction with various medical and other

organizations, would assist the local professional standards review organizations through providing them with model operational guides, forms and methodology descriptions. To the greatest extent possible, standardized forms and procedures should be utilized by the local review organizations. Of course, this approach would not preclude acceptable modification and adaptation to meet local circumstances, but basic formats should be established for national usage and basic comparable data for inter-PSRO comparisons should be developed.

It is expected that where economical and efficient computer and other resources already exist in carriers and intermediaries they would be utilized to the extent feasible and that operations would be consolidated and coordinated wherever possible. In a similar fashion, the PSRO could use the established communication channels of State and local medical associations to keep practicing physicians fully informed of review activities.

The committee would stress that the approach recommended does not envisage Blue Cross or Blue Shield or other insurance organizations or hospital or medical association review committees, assuming the review responsibilities for the professional standards review organizations. Where Blue Cross or Blue Shield or other insurers, or agencies have existing computer capacity capable of producing the necessary patient, practitioner, and provider profiles in accordance with the parameters and other requirements of the PSRO, on an ongoing expeditious and economical basis, it would certainly be appropriate to employ that capacity as a basic tool for the professional standards review organizations; but that mechanism would be employed essentially to feed computer printouts to the review organizations which would be responsible for their evaluation. Where it would facilitate administration, the Secretary could designate a specific carrier or intermediary as "lead" carrier or intermediary for purposes of coordination with PSRO's in an area. The responsibility for handling requests for such prior approval of hospital admissions, elective procedures and services as might be required, as well as the administrative mechanism for processing such requests, would lie with the PSRO's. A "lead" carrier or intermediary would not interfere with nor interrupt direct contact between the Secretary and the PSRO's.

It is expected that PSRO's would make specific arrangements with groups representing substantial numbers of dentists for necessary review of dental services.

PSRO's would be authorized and expected to retain and consult with other types of health care practitioners such as podiatrists to assist in reviewing services which their fellow practitioners provide. However, physicians should not be precluded—in fact they should be encouraged—to participate in the review of services ordered by physicians but rendered by other health care practitioners. For example, physical therapists may be utilized in the review of physical therapy services, but physicians should determine whether the services should have been ordered. The PSRO would be responsible for seeing to it that any arrangement it made was carried out effectively.

Expenses reasonably and necessarily incurred by the PSRO's, statewide councils and advisory groups and the national council would be borne by the Federal Government. Since overutilization of health serv-

ices is not restricted to medicare and medicaid but affects private health insurance as well, the PSRO would be at liberty to provide its review services to private health insurers provided the additional review efforts do not lower the quality of the medicare-medicaid reviews. In such a case, there would be a proportionate allocation of costs between medicare, medicaid, and others served by the review organization.

Employees of the PSRO would be selected by the organization and would not be Government employees. Where the Federal Government has paid for or supplied necessary equipment to the review organizations, title to such property would remain with the Government.

A PSRO agreement would include provision for orderly transfer of medicare and medicaid records, data and other materials developed during the trial period to the Secretary or such successor organization as he might designate in the event of termination of the initial agreement. Such transfer would involve only those records pertinent to medicare and medicaid patients and would be made solely for purposes of permitting orderly continuity of review activities by a successor PSRO.

Sanctions and Liability

It is anticipated that in those areas where PSRO's function effectively, the need for sanctions will be minimal. However, sanctions are provided under the amendment to deter improper activity.

On the basis of its investigations of situations of possible abuse identified in its own review or referred to it by the Secretary or his administrative agents, the PSRO would (after reasonable notice and opportunity for discussion with the practitioner or provider involved) recommend to the Secretary appropriate action against persons responsible for gross or continued overuse of services, for use of services in an unnecessarily costly manner, or for inadequate quality of services and would act to the extent of its authority and influence to correct improper activities.

In determining responsibility for overuse of services, uneconomical use of services or the provision of substandard services, the PSRO would take into account actual ability of the provider or physician to control the activities in question.

Where a review organization finds that voluntary and educational efforts fail to correct or remedy an improper situation with respect to a practitioner or provider, it would transmit its recommendations concerning sanctions through the statewide council to the Secretary of HEW. Protective appeals procedures are afforded to those against whom sanctions have been recommended. Where he receives such a recommendation, the Secretary could terminate or suspend medicare and medicaid payment for the services of the practitioner or provider involved, or assess an amount reasonably related to the excessive costs to the programs deriving from the acts or conduct involved—but not to exceed $5,000 against persons or institutions found to be at fault. In such cases the practitioner or provider would be granted a hearing by the Secretary on request and could seek judicial review of the final determination of the Secretary.

The amendment provides protection from civil liability for those engaged in required review activities, or who provide information to

PSRO's in good faith, for actions taken in the proper performance of these duties. Activities taken with malice toward a practitioner or institution, or group of practitioners would not be considered action taken in the proper performance of these duties. In addition, physicians and providers would be exempt from civil liability arising from adherence to the recommendations of the review organization (where it was a physician-sponsored and operated PSRO) provided they exercise due care in the performance of their functions. The intention of this provision in the amendment is to remove any inhibition to proper exercise of PSRO functions, or the following by practitioners and providers, of standards and norms recommended by the review organization. Thus, a physician following practices which fall within the scope of those recommended by a PSRO would not be liable, in the absence of negligence in other respects for having done so.

Failure to order or provide care in accordance with the norms employed by the PSRO is not intended to create a legal presumption of liability.

The exemptions from civil liability would apply to a range of patterns which fall within the scope of the norm, to the extent that such a range is considered acceptable by the PSRO in accordance with regulations of the Secretary. For example, the usual length of stay for a given illness might be 6 days, but an individual practitioner might only hospitalize his patient for 4 days. In this case the doctor might be motivated to keep his patient in the hospital for an extra 2 days to assure himself of exemption from liability. However, as described above, the PSRO could approve a range of norms, each of which was considered medically acceptable by the PSRO, which could encompass a hospital stay of 4 days as being sufficient. It is not intended, however, that this protection preclude the liability of any person who is negligent in performing PSRO functions or who misapplies or causes to be misapplied the professional standards promulgated by a review organization.

A physician or provider should not be relieved of responsibility where standards or norms are followed in an inappropriate manner or where an incorrect recommendation by the PSRO is induced through provision of erroneous or incomplete information.

Objective and impartial review must be provided by a PSRO if it is to be effective and respected. Malice, vendettas, or other arbitrary and discriminatory practices or policies are by definition "nonprofessional," and in the unlikely event of such occurrences the Secretary is expected to promptly act to terminate the contract with the organization involved unless it immediately undertakes voluntary corrective measures.

Hearings, Review and Waiver of Liability

A medicare beneficiary, medicaid recipient, provider of services or health care practitioner who was dissatisfied with a determination by a PSRO under this provision would be entitled to reconsideration of the determination by the PSRO; where the matter in controversy is $100 or more the reconsideration would be subject to review, on appeal, by a State Professional Standards Review Council or by the Secretary. Where the amount in question exceeded $1,000, the Secretary's

84-378 O - 72 - 7

final decision would be subject to judicial review. A review or appeal proceeding under the PSRO provision would be in lieu of any other review under the Social Security Act with respect to the same issue.

Generally, where the PSRO disapproved items or services furnished under medicare and medicaid, payment for such items and services could not be made by these programs. However, provision is made for the Secretary to make payment for disapproved items and services where he determined that a claimant was without fault with respect to the provision of items or services. This provision is needed to prevent making individuals liable for payment for the disapproved services when they accepted the services under the impression they would be paid for by medicare or medicaid.

State and National Organizations

Under the amendment statewide professional standards review councils (and an advisory group to each council) would be established in States which have three or more PSRO's. A council would consist of one representative from each PSRO, two physicians designated by the State medical society, two physicians designated by the State hospital association, and four persons, knowledgeable in health care, selected by the Secretary as public representatives. Two of the public representatives would be selected from nominees recommended by the Governor of the State.

A statewide council would serve to coordinate the activities of the PSRO's within the State, disseminate information and other data to them and review the overall effectiveness of each of the PSRO's operations. The council would be advised and assisted in its activities by an advisory group consisting of representatives of health care practitioners (other than physicians) and health care institutions.

Completing the structure, a national professional standards review council would be established. That council would consist of 11 physicians of recognized standing and distinction in the review of medical practice who would be appointed by the Secretary. A majority of the members would be selected from nominees of national organizations representing practicing physicians. The council would also include physicians nominated by consumer groups and other health care interests such as hospitals. The national council would arrange for the collection and distribution of data and other information useful to the statewide and local professional standards review organizations; particularly, norms of care employed in various geographic or medical service areas and various methods of utilizing and applying those norms. The national council would also report regularly to the Secretary and to the Congress on the overall and area-by-area effectiveness of the review program and offer such recommendations as it might have for improvement of the program.

Role of the Inspector General

Properly established and properly implemented throughout the Nation, professional standards review mechanisms can help relieve the tremendous strain which soaring health costs are placing upon the entire population. Emphasis, wherever possible, upon the provision of

necessary care on an outpatient rather than inpatient basis could operate to reduce need for new construction of costly hospital facilities. Hospital bed need would be further reduced by reductions in lengths of hospital stay and avoidance of admission for unnecessary or avoidable hospitalization.

To be effective, the PSRO provisions will require full and forthright implementation. Equivocation, hesitance, and half-hearted compliance will negate the intended results from delegation, with appropriate public interest safeguards, of primary responsibility for professional review to nongovernmental physicians. For these reasons, the committee expects that the Inspector General for Health Administration (whose office is established under another amendment) will give special attention to monitoring and observing the establishment and operation of the PSRO's to assure conformance and compliance with congressional intent.

Coverage of Certain Maintenance Drugs Under Medicare

(Sec. 215 of the bill)

Background

The committee added an amendment to the House bill which would provide coverage of certain maintenance drugs under part A of medicare. Medicare presently covers the cost of drugs given to an inpatient in a hospital or extended care facility, but does not, however, pay for prescription drugs on an outpatient basis.

Beneficiaries and others have frequently indicated the lack of coverage for outpatient drugs as the most significant gap in the medicare benefit structure. Prescription drug expenses account for a large part of the health expenses of older people. More important, perhaps, than the fact that drugs represent a large out-of-pocket expense for the elderly is that this expense is distributed unevenly among the elderly. Those with chronic illnesses such as heart or respiratory diseases are often faced with recurring drug expenses and many of these drugs are critical to the survival of these chronically ill patients. As a result, the elderly with chronic illnesses have, on the average, prescription drug expenditures nearly three times as high as those without chronic illnesses.

The committee believes that an outpatient prescription drug benefit is the most important and logical benefit addition to the Medicare program. However, the committee was quite concerned with the cost and administrative problems associated with proposals to cover all outpatient prescription drugs under medicare. Covering all drugs for the aged and disabled, with a $1 copayment, was estimated by the Social Security Administration to cost about $2.6 billion. In addition, the administrative burden of covering all drugs would be enormous since the program would have to deal with millions of small prescriptions, and the utilization controls to assure that prescriptions reimbursed under medicare were reasonable and necessary and used only by beneficiaries, would be quite cumbersome.

In studying the problems posed with respect to establishing an outpatient drugs benefit, the committee concluded that the problems could in large part be surmounted by an approach which focused on provid-

ing specified drugs which are necessary for the treatment of the most common crippling or life-threatening chronic diseases of the elderly. This approach would have four advantages: (1) It would result in the medicare dollar being targeted toward patients with chronic diseases who need drugs on a continuing basis for a lengthy period of time; (2) it would substantially simplify administration of a drugs benefit; (3) it would incorporate almost self-policing utilization controls at a relatively low administrative cost, since the program would involve only a relatively small number of drug entities and the necessity for these drugs would be comparatively easy to establish; and (4) this approach would substantially lower the cost of providing a drugs benefit. The cost of the amendment is estimated at $740 million for the first full year beginning July 1, 1973.

The committee approach is consistent with the recommendation of the Task Force on Drugs of the Department of Health, Education, and Welfare. The Task Force, in accordance with the Social Security Amendments of 1967, undertook many months of study concerning the appropriateness and possible methods of covering drugs under medicare. In their final report, issued in February 1969, the Task Force stated:

> "Available data on drug use by the elderly support the hypothesis that coverage of only those drugs which are important for the treatment of chronic illness among the elderly, and which usually are required on a continuing or recurring basis, would concentrate the protection provided by a drug program where it is most clearly needed."

After reviewing the relative advantages of this approach, the Task Force recommended:

> "In order to achieve maximum benefits with whatever funds may be available, and to give maximum help to those of the elderly whose drug needs are the most burdensome, the Task Force finds that particular consideration should be given to providing coverage at the outset mainly for those prescription drugs which are most likely to be essential in the treatment of serious long-term illness."

The committee commends the Task Force for its exhaustive and definitive efforts and agrees with its recommendation.

Summary of Committee Amendment

Basically, the committee amendment would cover specific drugs necessary for the treatment of the many crippling or life-threatening diseases of the elderly with the beneficiary subject to a copayment of $1 per prescription.

The chronic illnesses covered under the amendment were carefully chosen. The Task Force on Prescription Drugs issued a voluminous study containing extensive data with respect to drug utilization among the elderly. The table below, taken from the Task Force report, lists the more common chronic illnesses of the elderly, in order of the number of prescriptions related to each condition.

DESCENDING ORDER FOR NUMBER OF PRESCRIPTIONS USED IN TREATMENT OF ILLNESSES AMONG THE AGED

[Excluding mental conditions, gastrointestinal disorders, chronic skin diseases and anemia]

Diagnosed Conditions	*Number of Rx's in thousands*
Heart	46,512
High blood pressure	19,681
Arthritis and rheumatism	17,343
Genito-urinary conditions	9,127
Diabetes	8,085
Colds, coughs, throat conditions and influenza [1]	7,504
Other disorders of circulatory system	4,776
Injuries and adverse reactions [1]	4,000
Neoplasm	3,701
Eye	3,683
Emphysema	2,766
Asthma and hay fever	2,547
Other respiratory conditions	2,415
Sinus and bronchial conditions	2,138
Ear	2,113
Pneumonia	1,531
Thyroid	1,491

[1] Not included in amendment because of generally short-term nature of condition and need for prescriptions.

The amendment would cover serious chronic conditions necessitating long-term drug treatment with the exception of mental and nervous conditions, chronic skin disease, anemia, and gastrointestinal disorders. These diagnoses are excepted because many of the drugs used in their treatment (for example, tranquilizers, antacids, antispasmodics, antidiarrheals, vitamins, iron, and skin ointments) are drugs which are also used by many people for general reasons and are, therefore, difficult to confine to appropriate usage by beneficiaries only (for example, they could be acquired for use by nonbeneficiaries) as opposed to drugs such as insulin or digitalis which are almost invariably used only by those who have a specific need for them. In addition, concern has been expressed that coverage of the "major" tranquilizers used in the treatment of mental illnesses might encourage over-prescribing of potent tranquilizers for older people.

The amendment would further limit coverage to only certain drugs used in the treatment of covered conditions. In other words, people with chronic heart disease often use digitalis drugs to strengthen their heartbeat, anticoagulant drugs to reduce the danger of blood clots and other drugs to lower their blood pressure. These types of drugs would be covered under the amendment as they are necessary in the treatment of the heart condition and they are not types of drugs generally used by people without heart conditions. However, other drugs which might be used by those with chronic heart conditions (such as sedatives, tranquilizers and vitamins) would not be covered as they are drugs which are generally less expensive, less critical in treatment and much more difficult to handle administratively, as many patients without chronic heart disease may also utilize these types of medications.

The provision is designed to establish a basis for coverage of drugs capable of administration at reasonable cost. In this form and scope

it is an approach capable of providing significant help and of allowing for orderly future expansion if that were later decided.

It is expected that the Formulary Committee will study the problems related to the question of possible medicare coverage of drugs used in the treatment of mental illness with particular attention to development of means of assuring appropriate usage of such drugs. The Formulary Committee would submit to the Congress, through the Secretary, a report concerning its findings, conclusions and recommendations with respect to this matter.

Eligibility

All persons covered under part A of medicare would be eligible for the new outpatient drugs benefit. Under the provision, the drugs covered are necessary in the treatment of the following conditions:

- Diabetes
- High blood pressure
- Chronic cardiovascular disease
- Chronic respiratory disease
- Chronic kidney disease
- Arthritis and Rheumatism
- Gout
- Tuberculosis
- Glaucoma
- Thyroid disease
- Cancer
- Epilepsy
- Parkinsonism
- Myasthenia gravis

The fact that the patient needs the drug would indicate that he suffers from one of the above illnesses. Thus generally the existence of a specific chronic illness would not have to be established in connection with the application for payment for the prescription.

Benefits

The covered drug therapeutic categories are as follows:

- Andrenocorticoids
- Anti-anginals
- Anti-arrhythmics
- Anti-coagulants
- Anti-convulsants (excluding phenobarbital)
- Anti-hypertensives
- Anti-neoplastics
- Anti-Parkinsonism agents
- Anti-rheumatics
- Bronchodilators
- Cardiotonics
- Cholinesterase inhibitors
- Diuretics
- Gout suppressants
- Hypoglycemics
- Miotics
- Thyroid hormones
- Tuberculostatics

Within these categories, eligible drugs would be those prescription drug entities which are included by dosage form and strength in the Medicare Formulary described below. The amendment would exclude drugs not requiring a physician's prescription (except for insulin), drugs such as antibiotics which are generally used for a short period of time and drugs such as tranquilizers and sedatives which may be used not only by beneficiaries suffering from serious chronic illnesses, but also by many other persons as well. Beneficiaries would incur a $1 copayment obligation for each prescription. They would also be

obliged to pay any charges in excess of the product price component of the reasonable allowances where a higher-priced product of a drug included in the Formulary was prescribed and where the allowances were based upon generally available lower cost products (see "reasonable allowance" below). Payment under this program would not be made for drugs supplied to beneficiaries who are inpatients in a hospital or skilled nursing facility because their drugs are already covered under medicare.

Formulary Committee

To assure rational and professional control over the drugs covered and the cost of the drugs benefit, and to assure that funds are being targeted toward the most necessary drug entities within each covered therapeutic category, a Medicare Formulary would be established.

The Formulary would be compiled by a committee consisting of five members, a majority of whom would be physicians. The members would include the Commissioner of Food and Drugs and four individuals of recognized professional standing and distinction in the fields of medicine, pharmacology or pharmacy who are not otherwise employed by the Federal Government and who do not have a direct or indirect financial interest in the economic aspects of the committee's decisions. Members would be appointed by the Secretary for 5-year staggered terms and would not be eligible to serve continuously for more than two terms. The Chairman would be elected by and from the public members for renewable one-year terms.

It is expected that appointees to the Formulary Committee will have the stature and expertise to assure objective effort and informed decision-making of a level engendering public and professional confidence in their integrity and judgment.

The Formulary Committee would be authorized, with the approval of the Secretary, to engage or contract for such reasonable technical assistance as it determined it might need from time to time to enhance its capacity for judgment concerning inclusion of drugs in the Formulary. This could include utilizing the services of the committees and technical staff of the official compendia (the United States Pharmacopeia and the National Formulary). The committee expects that such contracting would be undertaken on a limited ad hoc basis, and will be used to supplement, as necessary, the services available within the Department.

The Formulary Committee's primary responsibility would be to compile, publish, and revise periodically a Medicare Formulary which would contain a listing of the drug entities (and dosage forms and strengths) within the therapeutic categories covered by the program which, based upon its professional judgment, the committee finds necessary for proper patient care, taking into account other drug entities included in the Formulary. To aid fully its consideration as to whether a drug entity should be included in the Formulary, the Formulary Committee would be authorized to obtain any records pertaining to a drug which were available to any other department or agency of the Federal Government and to request of suppliers of drugs and other knowledgeable persons or organizations pertinent information concern-

ing the drug. The committee would be authorized to establish procedures which it might require to determine the appropriateness of including or excluding a given drug from the Formulary.

The Formulary Committee would exercise utmost care in maintaining the confidentiality of any material of a confidential nature made available to it.

For purposes of inclusion in or exclusion from the Formulary of any drug entity (in a given dosage form and strength), the principal factors to be taken into account by the committee would be: (1) Clinical equivalence, in the case of the same dosage forms in the same strength of the same drug entity; and (2) relative therapeutic value in the case of similar or dissimilar drug entities in the same therapeutic category. The price of a drug entity would not be a consideration in the judgment of the Formulary Committee.

In considering which drug entities and strengths, and dosage forms, to include in the Medicare Formulary, the Formulary Committee is expected, on the basis of its professional and scientific analysis of available information, to exclude such drugs as it determines are not necessary for proper patient care taking into account those drugs (or strengths and dosage forms) which are included in the Formulary.

For example, in their consideration of drug entities in the therapeutic category known as anti-anginals, a therapeutic category included in the covered categories, the Formulary Committee would be expected to take into account professional appraisals such as the following which appears in "Drug Evaluations—1971," an authoritative publication of the American Medical Association:

> "The effectiveness of the short-acting agents, such as nitroglycerin and amyl nitrite, has been established through many years of use. * * * The oral administration of the so-called 'long-acting nitrates e.g., pentaerythritol tetranitrate, . . . erythrityl tetranitrate, . . . isosorbide-dinitrate, as well as some preparations of nitroglycerin are alleged to reduce the number of episodes and the severity of the pain of angina pectoris. The effectiveness of these agents is even more difficult to determine than that of the short-acting nitrates, and thus the beneficial value of their long-term use is controversial. * * * Thus, it cannot be concluded that the long acting nitrates are of definite therapeutic value for prolonged use.
>
> "Many products are available that contain a mixture of antianginal agents or an antianginal agent with a sedative or other drug(s); however, none of these fixed-dose combinations is rational. There is no evidence that a combination of antianginal agents has any advantage over the individual agents and, if more than one type of drug is needed, they should be prescribed separately."

The above quotation is illustrative of the type of source and information to which the Formulary Committee is anticipated to give serious consideration and weight in determining those drug entities (and dosage forms and strengths) which are reasonably appropriate as eligible drugs for purposes of medicare reimbursement.

Prior to removing any drug entity (or a particular dosage form or strength) from the Formulary, the committee would afford reasonable opportunity for a hearing on the matter to persons engaged in manufacturing or supplying the drug involved. Similarly, any person manufacturing or supplying a drug entity not included in the Formulary, but which he believed to possess the requisite qualities for inclusion, could petition the committee for consideration of the inclusion of his drug and, if the petition was denied, might, at the discretion of the committee, upon reasonable showing to the Formulary Committee of ground for a hearing, be afforded a hearing on the matter.

In addition to the list of drug entities included in the Formulary, the Formulary would also include a listing of the prices (generally the average wholesale prices) at which the various products of the drug entities are usually sold by suppliers to establishments dispensing drugs.

The Formulary Committee would be solely responsible for professional judgment as to which drug entities (and dosage forms or strengths) are included in the Formulary. The Secretary would not be involved in the making of those professional determinations.

Reimbursement

Reimbursement would be based, generally, on the average wholesale price at which the prescribed product of the drug entity included in the Formulary is sold to pharmacies plus a professional fee or other dispensing charges, except that reimbursement could not exceed an amount which, when added to the copayment required of the beneficiary, exceeded the actual customary charge at which the dispenser sells the prescription to the general public.

Both components of the reimbursement would be subject to overall limitations just as medicare's reimbursement to physicians, hospitals and other suppliers is subject to overall limitations. The professional fee or other dispensing charge would not be recognized for medicare reimbursement purposes to the extent that it was in excess of the 75th percentile of fees or charges for other pharmacies in the same census region. In establishing the 75th percentile limit in an area where some pharmacies use one system of calculation and others use a different system, it is the intent that the 75th percentile of charges be calculated independently for the two systems only where a substantial number of pharmacists in an area used each of the methods of charging for dispensing costs. Otherwise, use of the percentile would have the result that a scattering of pharmacists using a given form could set their own limit which might not be reasonable in relation to the usual practices in a community. In order to avoid this undesirable effect, where only a few pharmacists in an area used a given form of dispensing charge, the limit on this charge would normally be set at a level essentially equivalent to the 75th percentile for the form of dispensing charge most frequently used by pharmacists in an area. In determining the 75th percentile, pharmacies with a lesser volume of prescription business would be compared with each other and all larger volume pharmacies would be similarly compared with each other.

Increases in the prevailing professional fees or other dispensing charges would be recognized in a manner similar to recognition of

increases in prevailing physicians' fees. That is to say, increases in prevailing fees or dispensing charges could be recognized (not more than annually) up to limits established for program purposes by factors based upon changes in costs of doing business and average earnings levels in an area during a given period of time. A given pharmacy could change from a professional fee to another dispensing charge basis or vice versa, but for program reimbursement purposes the net effect of such change should be neutral.

Program payment for the drug entity (in given dosage forms and strengths) would be limited to reasonable allowances determined by the Secretary on the basis of the average wholesale prices at which the various products of the drug entity (in a given dosage form and strength) are commonly sold to pharmacies in a region plus the professional fee or dispensing charge. The beneficiary would be obligated to pay $1 of the reasonable allowance. If there was only one supplier of a drug entity, the price at which it was generally sold (plus the fee or dispensing charge) would represent the reasonable allowance. If, however, several products of the drug (in the same strength and dosage form) were generally available, reasonable allowances would be established which would encompass the lower priced products which were generally available and sold to pharmacies in a region. The number of lower priced products selected would stop at the point where reasonable availability of the drug entity is assured. In the latter case, other products of the drug entity (in the covered dosage form and strength) could also be reimbursable—even though not specifically included in the range of lower-priced products—where the average wholesale price of any such product was at or below the point used by the Secretary in establishing a reasonable allowance. This procedure avoids the problem of having to list every eligible drug product falling within the range of acceptable supplier prices in order for it to be reimbursable.

Products of a drug entity included in the Formulary which are priced above the highest reasonable allowance would be reimbursable but only to the extent of the highest reasonable allowance. The beneficiary would be obligated to pay the excess cost.

There would be three circumstances under which the program payment for a prescription could exceed reasonable allowances. First, if the supplier of a given drug product (of a drug entity in a strength and dosage form included in the Formulary) can demonstrate to the Formulary Committee that his product possesses distinct therapeutic advantages over other products (of the same dosage form and strength) of that drug entity, then the reasonable allowance for that drug product would be based upon the price at which it was generally sold to pharmacies. Second, where the Formulary Committee believed there was legitimate question concerning the clinical equivalency of the various products of different suppliers of a covered drug entity (or of given dosage forms and strengths) the Formulary Committee would be expected to list all of the products of the covered drug entity (in the dosage forms and strengths in question) so as to provide the prescriber with complete discretion until such time as the matter was resolved. Thus, the reasonable allowance would be based upon the reasonable customary price to the pharmacy for the product prescribed by

the physician in such cases. Third, if the physician felt in a specific instance that a particular manufacturer's product of a drug entity included in the Formulary, but which was priced above the highest product price component of the reasonable allowance, provides superior therapy to his patient and if he prescribes that product in his own handwriting by its established name and the name of its supplier, the reasonable allowance for the product would be based upon the price at which it was generally sold to pharmacies. Thus, a physician's reasonable discretion to prescribe a particular product of a drug entity included in the Formulary would be accommodated. In such cases, however, the reasonable allowance would not be greater than the actual usual or customary charge at which the pharmacy sells that particular drug product to the general public. The committee expects that these unusual prescribing situations will occur in only a small percent of cases, and this procedure would not negate the overall medicare requirement that services be reasonable and necessary. The Professional Standards Review Organizations (or, in the absence of a PSRO, other appropriate professional review), would be available to routinely review prescribing practices.

In circumstances other than those described above, where the cost of the drug product prescribed by the physician exceeds the highest product price component of the reasonable allowance, the beneficiary would be liable for charges to the extent of this excess including any related dispensing fee or charge.

Ordinarily, however, the beneficiary's obligation would be $1 per prescription, with the program paying the balance to the pharmacy.

Reimbursement to providers participating under medicare for other than the drugs program (such as hospitals) would be made on the regular reasonable costs basis.

In the case of insulin, reimbursement would be made to a pharmacy for its reasonable, usual and customary charge to the general public, plus a reasonable billing allowance less the $1 copayment.

Reimbursement would generally be made only to participating pharmacies. The exception would be that payment may be made for covered drugs dispensed by a physician where the Secretary determines that the drug was required in an emergency or that no pharmacy was reasonably available in the area.

Participating Pharmacies

As mentioned above, reimbursement under this program would be limited to participating pharmacies. No program reimbursement would be made either to the beneficiary or to a pharmacy where the prescription was dispensed by a non-participating pharmacy. The use of participating pharmacies would substantially decrease the administrative costs of the program, as participating pharmacies would generally submit batches of prescriptions and the program would not need to reimburse individual beneficiaries on a prohibitively costly prescription-by-prescription basis.

Such pharmacies would have to be licensed (where required) in the State in which they operate and would have to meet conditions of participation established by the Secretary of Health, Education, and Welfare. Participating pharmacies would file with the Secretary

a statement of their professional fee or dispensing charges (including minimum charges) as of June 1, 1972, so that the Secretary could determine the initial prevailing fee or charges in the census region for purposes of calculating reasonable allowances.

Participating pharmacies would agree to accept medicare reimbursement as payment in full and would further agree not to charge the beneficiary more than $1 copayment (except to the extent that a product prescribed by a physician was one whose cost exceeded the reasonable allowance).

The participating pharmacy would be paid directly by medicare on a prompt and timely basis with respect to eligible prescriptions submitted. The prescriptions from each pharmacy would be audited from time to time, on a sample basis to assure compliance with program requirements.

ADMINISTRATION

The committee amendment has been structured in such a way as to simplify and facilitate provision of and payment for benefits.

However, the committee has chosen not to specify a particular method or mold of administration. Because this is a new benefit, it is difficult to forecast which methods or organizational structures might most suitably implement the committee's intent that the drugs benefit be administered in the most efficient, expeditious and economical fashion. Fulfillment of the committee's intent would not necessarily entail uniform organization and procedures in each region. The Secretary could find that different means of administration in different regions or areas were appropriate in achieving the administrative objectives of the committee.

Inspector General for Health Administration

(Sec. 216 of the bill)

Based upon its years of inquiry and extensive examination of the medicare and medicaid programs, the committee found that these programs have suffered from the lack of a dynamic and ongoing mechanism with specific responsibility for continuing review of medicare and medicaid in terms of the effectiveness of program operations and compliance with congressional intent.

While the Comptroller General and the Department of Health, Education, and Welfare's Audit Agency have done some valuable and helpful work along the above lines, there is a pronounced need for vigorous day-to-day and month-to-month monitoring of these programs, conducted by a unit relatively free of constant pressures from various nonpublic interests at a level which can promptly call the attention of the Secretary and the Congress to important problems and which is charged with authority to remedy such problems in timely, effective, and fully responsible fashion.

To achieve the above objectives, the committee has approved an amendment which would establish an Office of Inspector General for Health Administration in the Department of Health, Education, and Welfare. The amendment is similar to the amendment approved by

the committee in 1970 and included in H.R. 17550 as passed by the Senate.

The responsibilities and role envisaged for the Inspector General for Health Administration are essentially patterned after the successful approach employed in the Agency for International Development and the investigative and reporting responsibilities, with respect to congressional requests, required of the U.S. Tariff Commission.

The Inspector General would be provided with authority sufficient to assure that medicare and medicaid function as Congress intends.

He would be appointed or reappointed by the President with the consent of the Senate for a term of 6 years. A Deputy Inspector General and such additional personnel as are necessary to carry out the functions of the Inspector General's office are also authorized.

The Inspector General is to report directly to the Secretary of HEW and in carrying out his responsibilities he is not to be under the control of, or subject to supervision by, any officer of HEW other than the Secretary.

The Inspector General will have the duty and responsibility of arranging, conducting, or directing reviews, investigations, inspections, and audits of medicare, medicaid, and any other programs of health care established under the Social Security Act as he considers necessary for determining—

(*a*) Efficiency and economy of administration;

(*b*) Consonance with provisions of law; and

(*c*) The attainment of the objectives and purposes for which the provisions of law were enacted.

He will be required to maintain continuous observation and review of the programs to determine the extent to which they comply with applicable laws and regulations and to evaluate the extent to which the programs attain the legislative objectives and purposes. The Inspector General is to make recommendations for correction of deficiencies or for improving the organization, plans, procedures, or administration of the health care programs.

In carrying out his duties, the Inspector General will have access to all records, reports, audits, reviews, documents, papers, recommendations, or other material of or available to the Department of Health, Education, and Welfare which relate to the health care programs. The head of any Federal department, agency, bureau, office, et cetera, and the head of any State agency administrating an approved medicaid plan would also, upon his request, provide any information which the Inspector General determines would assist in the carrying out of his responsibilities.

The Inspector General will have authority to suspend (upon at least 30 days' notice to the Secretary) any regulation, practice, or procedure employed in the administration of any of the health care programs if he determines (as a result of any study, investigation, review, or audit) that the suspension will promote efficiency and economy in the administration of the program, or that the regulation, practice, or procedure involved is contrary to or does not carry out the objectives and purposes of applicable provisions of law. Any suspension would remain in effect until an order of reinstatement was issued by the Inspector General except that the Secretary might, at any time prior to or after any such

suspension by the Inspector General, issue an order revoking the suspension.

When the Inspector General issued any order of suspension or reinstatement, he would promptly notify the Committee on Ways and Means of the House of Representatives, the Committee on Finance of the Senate and, in the case of an order relating to a State medicaid plan, the Governor or other chief executive officer of the State, of the order, and submit to them information explaining the reasons for suspension or lifting of suspension. Where the Secretary terminates an order of suspension issued by the Inspector General, he is required also to submit an explanation of his reasons to the two committees.

Where the Inspector General issues an order suspending any State regulation, practice, or procedure regarding its approved medicaid plan, and the State fails to comply with the order, the amount of Federal medicaid payment due the State during the period it so fails to comply will be reduced by an amount equal to the excess of the Federal medicaid funds payable to the State during the period it so fails to comply over the amount of Federal funds payable to the State if it had complied with the order.

The Inspector General could submit to the Committees on Ways and Means and Finance such reports relating to his activities as he deemed appropriate. He would, upon the request of either committee for any information, study, or investigation relating to, or within his responsibilities, cause such information to be furnished and such study or investigation to be undertaken.

This new office, with lines of communication direct to the Secretary of the Department and to the concerned committees of Congress, will make a major—and badly needed—contribution to the efficiency of the massive Federal health programs reflected in the medicare and medicaid statutes.

Expenses of the Inspector General are authorized in such amounts as are necessary to carry out the purposes of the amendment with the Secretary of HEW allocating proportions of the total amount to the various health care programs and trust funds involved.

The Inspector General may make confidential expenditures of up to $50,000 in any fiscal year, except that not more than $2,000 may ever be paid with respect to any one individual. He would submit an annual confidential report of any such expenditures to the Committee on Finance and to the Committee on Ways and Means.

Medicaid Coverage of Mentally Ill Children

(Sec. 299B of the bill)

Under present medicaid law, reimbursement for inpatient care of individuals in institutions for mental diseases is limited to those otherwise eligible individuals who are 65 years of age or older.

Matching for outpatient care for mentally ill children, as well as needy adults, is currently available under title XIX. The committee supports use of these funds where appropriate, and believes that outpatient treatment in the patient's own community should be used wher-

ever possible. However, in some cases, inpatient care in an institution for mental diseases is necessary.

The committee amendment would therefore authorize Federal matching under medicaid for eligible children, age 21 or under, receiving active care and treatment for mental diseases in an accredited medical institution. The definitions of active care and treatment in accredited mental institutions are those applicable to psychiatric institutional care under the medicare program. An appropriate "maintenance of effort" provision is included to assure that the new Federal dollars are utilized to improve and expand treatment of mentally-ill children.

The committee believes that the nation cannot make a more compassionate or better investment in medicaid than this effort to restore mentally ill children to a point where they may very well be capable of rejoining and contributing to society as active and constructive citizens.

The committee also believes that the potential social and economic benefits of extending medicaid inpatient mental hospital coverage to mentally ill persons between the ages of 21 and 65 deserves to be evaluated and has therefore authorized demonstration projects for this purpose.

The amendment is effective January 1, 1973.

Uniform Standards for Skilled Nursing Facilities Under Medicare and Medicaid

(Sec. 246 of the bill)

Under current law, skilled nursing facilities wishing to participate in both the medicare and medicaid programs are subject to similar conditions of participation although there are differences in the way regulations governing participation in the two programs are interpreted and applied from State to State.

While the emphasis of the care in skilled nursing facilities covered under the two programs differs somewhat—medicare focusing on the short-term care patient and medicaid on the long-term care patient—patients in these facilities intended to be covered under both plans require the availability of essentially the same types of services and are often in the same institution. Indeed, not infrequently, after expiration of medicare benefits, the patient may remain in the same facility—even in the same room—continuing on as a medicaid recipient.

Because of the substantial similarities in the services required of skilled nursing facilities under the two programs, the existence of separate requirements (which may differ only slightly) and separate certification processes for determining institutional eligibility to participate in either program is both administratively cumbersome and unnecessarily expensive. The same facility is more often than not approved to provide care under both medicare and medicaid. The committee believes therefore that it would be desirable to apply a single set of requirements to skilled nursing facilities under both medicare and medicaid.

The committee amendment provides for a single definition (skilled nursing facility) and a single set of requirements for the skilled nursing home and the extended care facility. The definition would incorporate the best features of the medicaid and medicare requirements. The amendment would further provide that facilities which satisfy the new definition of "skilled nursing facility" under one program shall be eligible to participate in the other provided it agreed to contract terms. The amendment would incorporate the present medicare definition and requirements for an extended care facility and would add the following three requirements:

> (a) That it supply full and complete information as to the identity of each person having (directly or indirectly) an ownership interest of 10 percent or more in such facility; in case a facility is organized as a corporation, of each officer and director of the corporation; and in case a facility is organized as a partnership, of each partner; and promptly report any change which would affect the current accuracy of the information so required to be supplied;
>
> (b) That it cooperate in an effective program of independent medical evaluation and audit of the patients in the facility;
>
> (c) That it meet such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to nursing homes; except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing facility, but only if such waiver will not adversely affect the health and safety of the patients

A single consolidated survey would be performed at least every 12 months to determine a facility's qualifications for both medicare and medicaid.

The committee's amendment is not intended to result in any dilution or weakening of standards for skilled nursing facilities. As at present, a State may continue to require higher standards of skilled nursing facilities than those mandated by Federal statute and regulation. Where a State imposes additional requirements in its own right, then, as under the present section 1863, those standards would apply to both medicare and medicaid skilled nursing facilities in the State.

This amendment incorporates the general thrust of an amendment previously developed by the committee and included in H.R. 17550.

The amendment is effective July 1, 1973.

Definition of Care in Skilled Nursing Facilities

(Sec. 247 of the bill)

The committee bill contains a provision which would conform the definition and the participation standards for skilled nursing facilities under medicare and medicaid. A common definition-of-care requirement under medicare and medicaid to assure that the benefits are payable on behalf of those types of patients who can best utilize the

skilled types of services available in such institutions would be consistent with the role these skilled nursing facilities should play in medical care.

The committee bill would establish a single common definition of care requirements for extended care services under medicare and skilled nursing services under medicaid as follows: Services provided directly by or requiring the supervision of skilled nursing personnel, or skilled rehabilitation services, which the patient needs on a daily basis, and which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis.

Skilled nursing services include: assessment of the total needs of the patient, planning and management of a patient care plan, observation and monitoring of the patient's responses to care and treatment, and rendering or supervising the rendering of direct services to the patient where the ability to provide the services or supervise the provision of the services requires specialized training.

Services such as help in walking and getting in and out of bed, assistance in bathing, dressing, feeding and using the toilet, preparation of special diets, and supervision of medication which can usually be self-administered and which does not require the continuing attention of trained paramedical personnel, would not be included as skilled nursing services. Of course, if a patient needed a variety of unskilled services on a regular daily basis, that patient could, nonetheless, be considered a skilled care patient if the planning and overseeing of the aggregate of the unskilled services required regular daily involvement of skilled personnel.

Some examples of services which meet the definition of skilled nursing services are:

—Intravenous or intramuscular injections and intravenous feeding. (Injections which can usually be self-administered—for example, the well-regulated diabetic who receives a daily insulin injection—do not require skilled services.)
—Levine tube and gastrostomy feedings.
—Naso-pharyngeal and tracheotomy aspiration.
—Insertion or replacement of catheters.
—Application of dressings involving prescription medications and aseptic techniques.
—Care of extensive decubitus ulcers and other widespread skin disorders.
—Initial phases of a regimen involving administration of medical gases.
—Restorative nursing procedures, including the related teaching and adaptive aspects of skilled nursing, which are part of active treatment and require the presence of licensed nurses at the time of performance, e.g., teaching the skills and facts necessary for understanding adherence to a regimen such as bowel and bladder training.

Both the availability of alternative health care facilities and services and the patient's condition would be taken into account in determining whether his need for care or supervision justifies the utilization of a skilled nursing facility rather than a more economical alternative. (In other words, if, in the case of medicaid, there were no intermediate

84-378 O - 72 - 8

care facility beds available, placement in a skilled nursing facility might be appropriate for a patient who did not need skilled services as defined above although, in such cases, reimbursement to the facility should be at a reduced rate commensurate with the services provided.)

The types of services which would be covered under both medicare and medicaid would include those skilled services which are essential to the rehabilitation and recovery of the patient, and also those which are necessary to prevent deterioration of the patient's condition and sustain the patient's current capacities even when full recovery or medical improvement is not imminent.

Since the principal aspect of covered care relates to the skilled services being rendered, the restorative potential of the patient is not controlling. Many patients who have no potential for rehabilitation require a level of care which is covered under the program. For example, a terminal cancer patient whose life expectancy is not more than a few months who requires palliative treatment, periodic "tapping" to relieve fluid accumulation, and careful skin care and hygiene to minimize discomfort is receiving care covered by this definition. Thus, the controlling factor in determining whether a person is receiving covered care is the skill and frequency involved and the supervision that the patient requires, rather than considerations such as diagnosis, type of condition, or degree of functional limitation.

In the case of medicare, the services must be a continuation of treatment of a condition for which the beneficiary received hospital services in the period immediately before his admission to the skilled nursing facility.

It has come to the committee's attention that the application of the definition of the extended care level of services can result in denial of medicare payment for services received in skilled nursing facilities by patients who are in regular need of skilled rehabilitation services (other than nursing) which are essential to their recovery from an inhospital stay or to prevent their condition from worsening and which as a practical matter should be provided in an institution. Often, transporting a patient from his home to a place where he may receive the needed rehabilitation is an excessive physical hardship on ill patients and uneconomical, especially when the patient requires ambulance transportation.

The recognition of a patient's need for skilled rehabilitative services as a basis for meeting the level of care requirement is intended to cover situations such as the following: (1) non-ambulatory stroke patients who need daily skilled rehabilitative services such as speech therapy, but who do not necessarily need skilled nursing services; and (2) hip fracture patients who need daily physical therapy services after the fracture has healed to the weight-bearing stage.

These kinds of services, however, would be covered only if they can as a practical matter be provided only in the skilled nursing facility setting because other arrangements that could be made to provide the needed services (e.g., bringing the services to the patient in his place of residence or daily transportation to an outpatient facility) are not practical because of the patient's condition or from the standpoint of efficient delivery of the required services. In determining whether other arrangements would be practical, the coverage or

noncoverage of the various alternatives under medicare or medicaid should not be taken into account—the issue is feasibility and not whether coverage is provided in one setting and not provided in another.

In some cases a skilled nursing facility may have patients who require only intermediate care rather than daily services which must be provided by or under the supervision of skilled personnel. When regular skilled care is not required, medicare would make no payment unless the care was received during a posthospital stay in which skilled services were normally required and provided there was only a day or two on which no skilled services were provided but discharge from the skilled nursing facility was not practical. Under medicaid, intermediate care is usually covered and would be paid for at an amount commensurate with the level of service required and provided, not at the amount paid for skilled care. However, a State could, with respect to those patients needing skilled care, as defined herein, reasonably classify such patients (for reimbursement or other appropriate purposes) so as to distinguish between those who require a greater or lesser range or quantity of skilled services or supervision.

The committee expects that the Professional Standards Review Organizations (established under another provision of the committee's bill) would provide scrutiny over whether appropriate patient placement was being made and that the Inspector General (also established under this bill) would also observe the operation of the provision.

The committee recognizes that the modified definition of care which would be reimbursable in skilled nursing facilities may have a substantial impact on extended care benefit costs. The Department of Health, Education, and Welfare has estimated that the cost of extended care benefits in skilled nursing facilities under medicare may increase some $90 million during the first full year of operation. However, the committee believes that to some extent these costs would be offset by reduced expenditures for hospital care and reduced medicaid expenditures. Under medicaid, the impact of the change will vary among the States, but to some degree it should have the effect of stimulating the removal of patients requiring only intermediate care or the reclassification of such patients in skilled nursing facilities which also provide intermediate care.

The amendment would become effective with respect to services furnished on and after January 1, 1973.

Authorization for the Secretary to Determine Whether a Facility Is Qualified to Participate as a "Skilled Nursing Facility" in Both Medicare and Medicaid

(Sec. 249A of the bill)

At present, the decision as to whether a skilled nursing home is qualified to participate in the medicaid program is ultimately determined by each State medical assistance agency (the title XIX agency). The facility makes application to the State medical assistance agency which in turn makes the arrangements for a survey of the facility by the surveying agency (generally the State health agency).

The title XIX agency reviews the survey findings and makes the final decision regarding the facility's qualifications for participation.

Unlike medicaid facilities, facilities participating in the medicare program are subject to a certification process which reduces—but does not totally avoid—State to State variability. The Secretary of Health, Education, and Welfare, acting through the appropriate Regional Office staff of the Social Security Administration, arranges for the State health agency to survey the facility desiring to participate under medicare and uses the results of the survey to make the final determination on certification of the facility.

Facilities certified to participate under both medicare and medicaid may be subject to differences in application of requirements inherent in the different certification operations of each program. The committee believes that present State certification of skilled nursing facilities has certain disadvantages, including lack of uniformity in application of standards to which all facilities are subject and duplication of certification efforts by State and Federal Governments. In addition, development of common standards for skilled nursing homes and extended care facilities as skilled nursing facilities, approved by the committee in another section of this bill, makes separate certification procedures unnecessary.

The committee's amendment provides, therefore, that determination of basic eligibility of skilled nursing home under title XIX be made by the Secretary. The appropriate State health agency would survey facilities wishing to participate in either (or both) the medicare or medicaid programs and report its findings and recommendations to the Secretary. The Secretary would make a determination as to eligibility and advise the State if a facility meets the basic requirements for participation as a skilled nursing facility.

A State could for good cause decline to accept as a participant in the medicaid program a facility certified by the Secretary. Good cause, for example, could include non-usage of a facility because an area is "overbedded" as determined by an areawide facilities plan or because the rates charged were out-of-line.

A State could not receive Federal matching funds for services provided by any facility not approved by the Secretary.

In applying uniform certification standards for skilled nursing facilities, the test will be whether the facility is in full compliance with all certification requirements. The State's judgment as to whether a facility is in full compliance with a requirement will be subject to the Secretary's review and approval. If it is determined that a facility is not in full compliance with one or more requirements (which do not jeopardize the health or safety of patients) reasonable time will be permitted for correction of deficiencies. Use of provider agreements without fixed expiration dates would not be continued because this procedure has in the past caused serious difficulties and delays in decertifying a facility with deficiencies. Therefore, a facility will be issued time-limited provider agreements of up to twelve-months duration. But in no case longer than the period allowed for correction of deficiencies as determined by the Secretary.

The Department would be provided with sufficient flexibility in applying this procedure in its initial year of implementation to estab-

lish a staggered schedule of surveys and expiration of contracts to avoid "peaking" of workloads. It would be expected that surveys would ordinarily be scheduled at least 60 days before the expiration of the contract.

Review and certification of intermediate care facilities would remain a State responsibility.

This amendment would be effective July 1, 1973.

Requirements for States Participating in Medicaid To Pay Skilled Nursing and Intermediate Care Facilities on a Reasonable Cost-Related Basis

(Sec. 249 of the bill)

Under the medicare program extended care facilities are reimbursed for the reasonable costs they incur in providing covered services plus, in the case of proprietary institutions, an allowance related to net capital equity. Under medicaid States have been free to develop their own bases for reimbursement to skilled nursing facilities and intermediate care facilities. States generally establish (in advance) per diem or similar basic rates payable for patients receiving skilled nursing facility and ICF care. Concern has been expressed that some skilled nursing facilities and ICF's are being overpaid by medicaid, while others are being paid too little to support the quality of care that medicaid patients are expected to need and receive.

On the other hand the reasonable cost reimbursement approach of the medicare program has in many cases created difficulties for extended care facilities. The detailed and expensive cost-finding requirements can prove cumbersome.

The committee bill would require States to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis by July 1, 1974. This approach is preferable to the arbitrary rate-setting currently in effect in some States which provide no incentive to facilities to upgrade the level of care provided. The States would use acceptable cost-finding techniques (not necessarily those utilized for medicare purposes) to determine reasonable reimbursement and apply to the results appropriate methodologies for determining payment. The methods would have to be approved and validated by the Secretary. The committee does not intend that this provision should require use of the specific medicare reasonable cost reimbursement formula by States for purposes of reimbursing skilled nursing homes and intermediate care facilities under medicaid, although States are free to choose this option. Rather, the States could develop other reasonable cost-related methods of rate-setting. Whatever methodology is authorized should include adequate procedures for auditing, as necessary, the financial records of an institution. States would not be required to reimburse for luxury services, questionable allowances for depreciation and similar items which they might reasonably choose not to recognize as "reasonable." States would be free to provide for retroactive adjustments of rates or costs to the extent necessary to prevent "windfalls" or unjustifiably low payment. The Secretary would be expected to validate, on site, a State's methodology through sample audits. Reasonable cost-related rates could be determined on a

geographic basis, a class basis, or on an institution-by-institution basis.

The committee amendment provides that cost reimbursement methods which the Secretary would find acceptable for a State's medicaid program would also be adapted, with appropriate adjustments, in the State for purposes of medicare reimbursement. The Secretary would be permitted to adjust a rate upward where appropriate, to reimburse for specific factors related to medicare requirements (such as keeping a reasonable number of beds available, type of occupancy covered, any additional administrative costs) which are not considered by the State or included in the computation of its medicaid rates. Such adjustments would be distilled into a percentage factor (not in excess of ten percent) so as to simplify reimbursement. These percentage adjustments may be made on a geographic basis of classes of facilities and not necessarily on an institution-by-institution basis. A similar provision was included in H.R. 17550.

Where a skilled nursing facility is a distinct part of, or directly operated by a hospital, reimbursement would be made for care in such facilities in the same manner as is applicable to the hospital's costs. Where a skilled nursing facility functions in a close formal medical satellite relationship with a hospital (which would be defined in regulations of the Secretary) reimbursement would be made on the basis of costs not to exceed 150 percent of the adjusted medicaid rate of payment (if the Secretary applies such rates to medicare facilities in that State) for care in that facility (or comparable facility.

This approach avoids substantial auditing and cost-finding expense and provides a means of making equitable adjustments where appropriate.

Public Disclosure of Information Concerning Required Survey Reports of an Institution

(Sec. 299D of the bill)

At present, information as to whether a hospital, skilled nursing facility, or other organization fully meets the statutory and regulatory requirements relating to conditions for participation for medicare and medicaid or whether it has significant deficiencies, is generally available only to the facility involved, and certain State and Federal agencies. Physicians and the public, in general, are currently unaware as to which institutions have significant deficiencies and which do not. The committee believes that in the absence of public knowledge about the nature and extent of deficiencies of individual facilities, it is difficult for physicians and the public to rationally choose among health care facilities and to effectively direct their concern about short-comings to the deficient facilities and to bring pressures for improvement to bear on those facilities.

The committee believes that ready public access to timely information about the existence or absence of deficiencies (such as in areas of staffing, sanitation, fire and other safety requirements) would help substantially in encouraging facilities to correct their deficiencies and, at the same time, enable physicians and patients to make sound judg-

ments about their own use of available facilities in the community. Given the necessary information, the community should be able to exert greater influence on institutions to assure that they develop and maintain high standards of care.

The committee bill, therefore, requires the Secretary of Health, Education, and Welfare, following completion of a survey of a health care facility or organization, to identify and make available to the public information from the survey on the absence or presence of deficiencies in every significant area relating to requirements in titles XVIII and XIX and related regulations. Significant areas would include all statutory requirements such as those relating to nursing personnel, as well as other requirements the Secretary establishes by regulation for the health and safety of patients.

Information on the significant survey findings relative to individual institutions and other organizations identified in the course of a survey, would be available for public inspection in readily accessible form and fashion in Social Security district offices and local welfare offices upon request within 90 days of completion of a survey.

This provision is similar to the provision developed by the committee in 1970 and included in H.R. 17550 as passed by the Senate.

The provision is effective beginning with surveys completed after the sixth month following the month of enactment.

Validation of Services Made by the Joint Commission on the Accreditation of Hospitals in Medicare

(Sec. 244 of the bill)

Under present law an institution is deemed to meet the certification requirements of medicare (except for utilization review requirements) if such an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals (JCAH).

In addition, the law states, under the definition of a hospital, that an institution must meet such requirements as the Secretary finds necessary in the interests of health and safety, except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on the Accreditation of Hospitals. However, if a State sets higher standards for institutions within its jurisdiction for medicaid, these requirements are also used for medicare.

The JCAH, which consists of representatives of the American Medical Association, the American Hospital Association, the American College of Surgeons, and the American College of Physicians, has been surveying hospitals which voluntarily request accreditation since 1952. Two-thirds of the hospitals, including almost all large hospitals certified to participate in medicare, received such certification as a result of JCAH accreditation. Of over 6,700 hospitals approved to participate in medicare, about 4,500 have been certified on the basis of JCAH accreditation. About 2,300 additional facilities were certified by the Social Security Administration, following surveys performed by State health facility licensure agencies, as meeting statutory requirements and standards established by the Public Health Service.

Initially, the conditions of participation were linked to those of the JCAH to provide assurance to those who were concerned, prior to the enactment of medicare, that only professionally established conditions would have to be met by providers of health services who wished to participate in the medicare program as well as providing for use of a certification program which was operational before medicare. However, the committee has since found several areas of concern with respect to the JCAH role in the medicare certification process.

The JCAH survey process is not subject to Federal review, and all JCAH survey reports are confidential, available only to JCAH, itself, and the concerned facility. These elements prevailed, however, prior to medicare's enactment and were understood at the time of enactment of the program. No inference should be drawn that hospitals and the JCAH changed the "rules of the game" in any way. However, since JCAH survey reports are not available to the Government, the Federal agencies responsible to the Congress for the administration of medicare are not in a position to audit the validity of the overall JCAH survey process, and thus the Government is unable to determine the extent to which serious deficiencies may exist in these participating hospitals.

A further potential difficulty arises because, under present law, medicare cannot set standards which are higher than comparable JCAH requirements. This has been interpreted by the Social Security Administration to bar establishment of any standards in any area where JCAH has remained silent. Since the law does not refer to any specific JCAH standard, but rather to any standards prescribed by the JCAH, the law serves to provide an almost blanket delegation of authority over hospital standards to a private agency. Thus theoretically, if the Joint Commission chose to lower a standard, medicare would also be required to accept that reduced standard. Though the Federal Government is limited to JCAH standards, a State may promulgate higher standards for facilities within the State for State programs. Licensure requirements, of course, apply to all facilities.

The committee added to the House bill a provision developed with the complete cooperation of the Joint Commission, which would authorize the Secretary to enter into an agreement with any State under which the appropriate State or local certifying agency would survey JCAH-accredited hospitals on a selective and limited sample basis, or where the Secretary finds in the case of a given institution that a survey, or more limited investigation, is appropriate because he has received a substantial allegation with evidence, or believed to have substance, of the existence of a condition significantly adverse to the health or safety of patients. The Secretary is expected to establish procedures for orderly and timely submission and transmittal of any such allegations. Such a condition would exist when there is a lack of conformity with a standard or critical factor of medicare conditions of participation which would, under procedures applicable to nonaccredited hospitals, constitute a deficiency or deficiencies of such character as to seriously limit the capacity of the institution to render adequate care and to require State agency survey and followup action.

One or more Federal members could be added to a State team which has been assigned to survey an accredited hospital, to the extent that

the Secretary found it desirable in the interest of maintaining uniformity of results in carrying out sample studies, or to augment a survey team's capability. These sample and special surveys would serve as a mechanism to validate the JCAH survey process. If in the course of such a survey an institution were found to have significant deficiencies, following timely discussion of such deficiencies with JCAH the detailed medicare standards and compliance procedures would be applied in place of the general JCAH standard.

The requirements of this provision have been discussed with the JCAH and are generally acceptable to it as reasonable. The JCAH has offered its full cooperation and it is expected that the Joint Commission will be fully and continually consulted and involved (on a reimbursable basis, where appropriate) in the implementation of this provision. To implement the sample surveys and to follow up effectively on any deficiencies found the amendment provides that JCAH-accredited hospitals would have to agree, in order to qualify for reimbursement under medicare and medicaid, to authorize JCAH to furnish the Secretary and State health agencies, on a confidential basis, with copies of the JCAH survey report, when and if the hospital was to be surveyed. (Significant deficiencies found in medicare-medicaid surveys of accredited hospitals authorized under this provision would be subject to public disclosure under another provision of this bill.)

The Secretary would be authorized, after consultation with the JCAH, to promulgate standards, as necessary for health and safety, which may be higher or more precise than those of the JCAH and which all hospitals would have to meet after appropriate and adequate time for compliance. It is expected that this provision would seldom be used because, if a worthwhile improvement in accreditation requirements were identified by the Secretary, it would, in all probability, be adopted by the JCAH. If the JCAH, as a condition for accreditation of a hospital, requires a utilization review plan, or a substantially equivalent requirement, or imposes a standard which the Secretary determines is at least equivalent to the standard promulgated by him, the Secretary may find that all institutions so accredited by the JCAH comply with medicare standards.

The purpose of the committee amendment is to provide a mechanism for reasonable continuing validation of the voluntary accreditation process and not to duplicate that process. The Secretary would also be required to include in his Annual Report to the Congress on medicare an evaluation of the JCAH accreditation process as indicated by the survey process.

Medicare Coverage for Certain Individuals Aged 60–64

(Sec. 214 of the bill)

Present law provides hospital insurance protection for persons aged 65 and over who are insured or are deemed to be insured for cash benefits under the social security or railroad retirement programs. Essentially, all persons aged 65 and over are eligible to enroll for medical insurance (part B) without regard to insured status. The committee has approved a provision in the House bill which would permit persons

aged 65 and over who are not insured or deemed insured for cash benefits to enroll in part A at a premium rate equal to the cost of their protection.

The committee is concerned that many social security and railroad retirement cash beneficiaries aged 60–64 and spouses aged 60–64 of medicare beneficiaries find it difficult to obtain adequate private health insurance at a rate which they can afford. Frequently these older persons—retired workers, wives, husbands, widows, widowers, mothers, parents, brothers and sisters, for example—have been dependent for health insurance protection on their own group coverage or that of a related worker who is now retired or deceased. It is a difficult task for such older persons to secure comparable protection at affordable cost when they are not connected with the labor force.

The committee, therefore, has added to the House bill a provision which would make medicare protection (both part A and part B) available on an optional basis at cost to spouses aged 60–64 of medicare beneficiaries; others aged 60–64 who are entitled to retirement, wife's, husband's, widow's, widower's, mother's, parent's, or brother's and sister's benefits under social security and the railroad retirement programs; and disability beneficiaries aged 60–64 not otherwise eligible for medicare because they have not been entitled to cash disability benefits for 24 months. The availability of medicare protection would be limited to persons aged 60–64 because the committee believes that people under age 60 who are not disabled generally have relatively little difficulty in obtaining private health insurance. About 6 million persons aged 60–64 would be potentially eligible to enroll for medicare as spouses of medicare beneficiaries or as beneficiaries entitled to the benefits specified above.

Persons who elect to avail themselves of medicare protection under this provision would pay the full cost of such protection. Enrollees would pay a monthly part A premium based upon the estimated cost of hospital insurance protection for persons eligible to enroll plus amounts sufficient to cover administrative expenses and underwriting losses or gains, if any; such premium would be $33 a month through June 1974 and would be adjusted for each 12-month period thereafter to reflect both the experience of the group and any changes in costs.

The monthly premium for persons in the group who enroll for part B would be twice the premium paid by an individual who has attained age 65 until June 1974 and would be adjusted for each 12-month period thereafter to reflect the estimated cost of supplementary medical insurance protection for persons eligible to enroll under the provisions plus amounts sufficient to cover administrative expenses and underwriting losses or gains, if any. Aliens who have been in the United States less than 5 years and persons who have been convicted of certain subversive crimes would be excluded from participation under this provision, just as they are excluded from enrolling for supplementary medical insurance.

The committee bill would require, as it requires under the provision in the bill making medicare protection available to uninsured persons aged 65 and over, that in order for persons to be eligible to enroll for hospital insurance they must be enrolled for supplementary medical insurance. If a person terminates his supplementary medical

insurance, his hospital insurance coverage under this provision would be automatically terminated effective the same date as his supplementary medical insurance termination. The committee believes that such a restriction is necessary to reduce the possibility of excessive utilization of the more expensive hospital insurance coverage as might occur if an individual were enrolled for hospital insurance (covering primarily institutional care) but not for supplementary medical insurance (covering primarily outpatient care).

Coverage would be initially available as of July 1, 1973, to enrolled eligible persons.

Maternal and Child Health Project Grants

(Sec. 291 of the bill)

The 1967 Amendments to title V of the Social Security Act authorized $350 million for 1972 and each year thereafter for Maternal and Child Health Services. The 1967 provision contained an allocation formula which divided the title V authorizations as follows:

(*a*) 50 percent of any appropriations for formula grants to the States

(*b*) 40 percent of any appropriations for special project grants

(*c*) 10 percent of any appropriations for research and training grants.

The intent of this portion of the 1967 Amendments was to divide available funds in this fashion for a few years so that the Federal Government could fund innovative special projects which States might not be able to fund out of their formula grants. The special project grants were to terminate as of fiscal year 1973 and the project moneys converted to the formula grants. The rationale underlying this approach was that after a few years time, States would recognize the value of worthwhile projects and continue to support such project grants as part of an overall State program for improving maternal and child health.

Two problems have developed since the present law was enacted. First, the special project grants have been utilized primarily in urban areas, while the formula grants, on the other hand, are weighted in favor of rural States. Thus, a significant shift of funds from urban States with project grants to rural States without project grants would occur, if the project grant authorities were terminated as presently scheduled. Additionally, many project grant directors have indicated that because of other pressures on State finances, State health departments would be reluctant to use new formula grant funds to continue support for project grants, however worthy they might be.

The committee is concerned with the risk of terminating worthy projects and also recognizes the need for a full evaluation of performance under and reassessment of the maternal and child health program and its inter-relationship with broader issues of revenue sharing and national health insurance.

The Congress recently approved an extension of the project grant authority to June 30, 1973. To assist orderly budgeting by grantees and to provide time for proper evaluation of the program the Finance

Committee has approved an amendment which extends for an additional fiscal year (i.e., through June 30, 1974) the present special project grant authorization contained in title V.

Waiver of Beneficiary Liability in Certain Situation Where Medicare Claims Are Disallowed

(Sec. 213 of the bill)

Under present law, whenever a medicare claim is disallowed, the ultimate liability for the services rendered falls upon the beneficiary. This is true even where the program has paid the claim and subsequently reopens and disallows it. The result is that in many cases a beneficiary is liable for payment even though he acted in good faith and did not know that the services he received were not covered, and even though the hospital, physician or other provider of services was at fault.

The committee bill amends title XVIII so that the beneficiary could be "held harmless" in situations where claims were disallowed because the expenses were incurred for services which were not reasonable or necessary for the diagnosis or treatment of an illness or injury or where the expenses were for custodial care and the beneficiary was without fault. In such situations the liability would shift either to the Government or to the provider—depending upon whether the provider utilized due care in applying medicare policy in his dealings with the beneficiary and the Government.

Where both the provider and beneficiary exercised due care (i.e., they did not know, and had no reason to know, that noncovered services were involved), the liability would shift to the Government and payment would be made as though covered services had been furnished. However, in making such a payment it would be necessary to make certain that the provider and patient are put on notice that the service was noncovered with the result that in subsequent cases involving similar situations and further stays or treatments in the given case (or similar types of cases in the instance of the provider) they could not show they had exercised due care. Thus, the Government's liability would be progressively limited.

Where the provider did not exercise due care, but there was good faith on the part of the beneficiary, liability would shift to the provider. The provider would be told that he could appeal the intermediary's decision both as to coverage of the services and due care. If, on the other hand, he exercised his rights under State law and received reimbursement from the beneficiary, the program in turn would indemnify the beneficiary (subject to deductibles and coinsurance). The indemnification could then be treated as an overpayment against the provider and recovery would be effectuated through a set-off against any amounts otherwise payable to the provider.

Where the beneficiary was aware, or should have been aware, of the fact that the services were not covered, liability would remain with the beneficiary and the provider could either exercise his rights under State law to collect for the services furnished or appeal the determination through the SSA appeals process. Where expenses were incurred

for clearly noncovered services such as routine physical checkups, eyeglasses or eye examinations to determine the refractive state of the eyes, hearing aids or examinations therefor, routine dental services or immunizations there will be a presumption made that the beneficiary and/or the provider was aware, or should have been aware, of the fact that the services were not covered.

In providing for a waiver of liability in certain cases it is not the committee's intent to modify existing provisions of law which define covered services. However, the committee also does not intend that these provisions for waiver will be construed to encourage overly strict application of coverage provisions under the assumption that beneficiaries who cannot afford to pay for the noncovered services will be relieved of the obligation to do so. For example, inpatient hospital care is now covered under medicare only when hospital services are required on an inpatient basis from a medical standpoint. The decision as to the point in time when an individual no longer requires the hospital level of care—i.e., when he can be cared for as an outpatient or in a less costly type of facility—requires a careful exercise of professional judgment and considerable weight should be given to the attending physician's opinion because of his much greater familiarity with the patient's needs. Under certain circumstances, it may be reasonable to keep a medicare patient in the hospital even though he required only an extended care facility level of care. Sometimes there may be no extended care facility bed available. Or, there may be a period of a few days at the conclusion of a hospital confinement when a convalescing patient requires only an extended care level of services but where, as a practical matter, it would be unreasonable to transfer the patient to an extended care facility for such a short period of time. Similarly, there are situations where a terminal hospital patient could be discharged to another institution or his home a few days before his death but where it would not be economical or humane to do so. In these cases, it would continue to be appropriate to approve the few additional days of the hospital stay that are involved.

However, where the patient remains in the hospital beyond the point where it would have been practical to transfer him to a less intensive setting, coverage ends as of the time when, based on the information that was available at the time, it would be reasonable to expect the transfer to have been made. Payment of benefits for hospitalization beyond that point could be made only if the hospital's and patient's liability for the costs incurred can be waived.

The provision would be effective with respect to claims filed after the month of enactment or if filed before or in the month of enactment was for services provided on or after July 1, 1971, and for which final determinations have not been made.

Family Planning Services

(Sec. 299E of the bill)

The committee bill provides for an increase in Federal funding of family planning services for present and former welfare recipients of child-bearing age and also for those persons likely to become recipients

in the absence of such services by authorizing 100 percent Federal funding for State family planning programs, including both information counseling and the provision of medical and social services.

The committee believes that its amendment will give impetus to the availability and provision of family planning services in the States. A beginning was made in 1967, when provisions were included in the social security amendments which required that family planning services be offered on a voluntary basis, to all appropriate AFDC recipients, and authorized 75 percent Federal matching funds for this purpose. In addition the same matching was made available to the States on an optional basis for services for former or potential recipients of welfare.

The progress which has been made under the 1967 amendments, however, has not met the committee's expectations. The annual report by the Department of Health, Education, and Welfare covering family planning services includes information which makes clear that the mandate of the Congress that all appropriate AFDC recipients be provided family planning services has not been fulfilled. The report states:

> Many problems, of course, remain. Medical services [family planning] still are too limited, especially in rural areas but frequently in large urban areas as well. Replying to the question whether medical family planning programs currently available are adequate to meet the needs of eligible clients, 36 State welfare agencies answered in the negative in March, 1970. Thirty-one cited geographic inaccessibility as a major problem. Many reported a shortage of health professionals and paraprofessionals and some reported that existing facilities are overcrowded. Even in the Nation's principal counties and cities where clinics are more likely to be found than in less populous sections, 50 out of 106 local welfare agencies reported that currently available medical planning programs are inadequate.
>
> Looking at their own capability of providing family planning services, many State and local welfare agencies report a shortage of staff to provide services and to arrange for adequate follow-up. Training programs for staff have not been mounted on the scale required. Although Federal funds may be used to match $3 for every $1 spent from State funds for services, time and again agencies emphasize the difficulty of raising the 25 percent share at State and local levels. Generally, no special funds have been made available to develop family planning services, as indicated, for example, by the general absence of full-time staff leadership for this program. Expectations among some groups that title IV funds would be available to reach substantial numbers of low-income families not currently receiving welfare have not been realized. . . .

Evidence indicates the situation is not significantly improved today. The committee is persuaded that the 75 percent Federal matching percentage, although a major step in promoting family planning services, has not been sufficient to achieve the aims of the Congress. By

providing 100 percent Federal funding, the committee bill will remove any existing financial barrier to the availability of family planning counseling and services to those desiring those services.

The committee amendment would authorize States to make available on a voluntary and confidential basis family planning counseling, services, and supplies, directly and/or on a contract basis with family planning organizations (such as Planned Parenthood clinics and Neighborhood Health Centers) throughout the State, to present, former, or potential recipients including any eligible medically needy individuals who are of child-bearing age and who desire such services.

In addition to the provision of counseling, services and supplies designed to aid those who voluntarily choose not to risk an initial pregnancy, emphasis would be placed upon assisting those families with children who desire to control family size in order to enhance their capacity and ability to seek employment and better meet family needs.

The Secretary would be required to work with the States to assure that particular effort is made in the provision of family planning services to minors (and non-minors) who have never had children but who can be considered to be sexually active; for example, persons who have contracted venereal diseases, etc.

The Secretary would also be required to work with States to assure maximum utilization of persons participating in the Work Incentive Program as family planning aides and to perform related jobs.

In order to assure that States do in fact inform welfare recipients and other eligible persons of the availability of family planning services, and that those who so desire receive the necessary medical and counseling services the amendment would reduce the Federal share of AFDC funds by 2 percent, beginning with calendar year 1974, if a State in the prior year fails to inform at least 95 percent of the adults in AFDC families and on workfare of the availability of family planning services and/or if the State fails to actually provide or arrange for such services for 100 percent of those persons desiring to receive them.

Because of the difficulties of enforcing or monitoring the mandatory provision of family planning services to former or potential recipients, the penalty provision will be limited to the offering and provision of services to present adult recipients of AFDC and workfare. However, family planning services must be offered and made available on an optional basis to former and potential recipients of child-bearing age.

It is envisioned that individuals of child-bearing age applying for or receiving AFDC would formally acknowledge that they have been informed that they are eligible to receive family planning services on a voluntary and confidential basis. If they desire family planning services, an appointment would be set up at that time and a copy of the form would be sent to the clinic or physician providing necessary services and supplies. This would not preclude "walk-in" requests for family planning assistance by present and former recipients or those likely to become recipients in the absence of such services.

The effectiveness of the program would be monitored by Federal officials on a sample basis. The operation of the program would also be subject of review by the Inspector-General for Health Care Administration.

Although the committee views family planning services as primarily medical services, it also recognizes the importance of counseling and informational services which are more traditionally considered to be social services. Therefore, the Committee amendment makes 100 percent Federal financial support for family planning services available under both the title XIX and the title IV–A programs.

The committee has amended title XIX to provide that family planning services are a mandatory service under all title XIX plans. The committee intends that the 100 percent Federal funding of family planning services through titles XIX and IV–A will reimburse for the reasonable costs of directly related family planning services.

Penalty for Failure to Provide Required Health Care Screening

(Sec. 299F of the bill)

Under present medicaid law as defined in regulation by the Department of Health, Education, and Welfare, States are required to provide health screening and treatment services for all children under 6 and eligible for medicaid by February 7, 1972, and to provide screening and treatment services to all eligible children up to age 21 by July 1, 1973.

The medicaid health screening and treatment regulation requires States to assure that eligible children receive early and periodic screening and diagnosis to ascertain physical and mental defects, and treatment of conditions discovered, within the limits of the State plan; and that in addition, eye-glasses, hearing aids and other kinds of treatment for visual and hearing defects, and at least such dental care as is necessary for relief of pain and infection and for restoration of teeth and maintenance of dental health, will be available, whether or not otherwise included under the State plan, subject however to such utilization controls as may be imposed by the State agency.

Although States are required to provide treatment services indicated as necessary by the screening only to the extent that they are covered under the State plan or are required by the regulation, it is expected that States will be responsible for referring eligible children to other sources for uncovered services, and will make every effort to arrange for their provision. The regulation further requires States to establish administrative mechanisms to identify available screening and diagnostic facilities. States are also required to assure referral of appropriate children to the title V (maternal and child health) grantees for care and services, and to effect agreements to assure maximum utilization of existing screening, diagnostic, and treatment services provided by other public and voluntary agencies such as child health clinics, neighborhood health centers, day care centers, nursery schools, school health programs, family planning clinics, maternal clinics, and similar facilities.

The committee recognizes the significance of early detection and treatment of illness in children—both in human and economic terms—and therefore believes that the possibility of a reduction in Federal matching AFDC funds would serve to assure that States implement the title XIX requirements for health, screening, diagnosis, and treat-

ment for eligible children. Moreover, it would underline the committee's intent that the health screening programs should be fully implemented by the States.

The committee has therefore approved an amendment which specifies that the Federal share of AFDC matching funds would be reduced by 2 percent beginning in fiscal year 1975 if a State in the prior year has (a) failed to inform at least 95 percent of the AFDC families of the availability of child health screening services for children of ages eligible for such services; or (b) failed to actually provide for or arrange for such services; or (c) failed to arrange for or refer to appropriate corrective treatment children disclosed by such screening as suffering illness or impairment.

Because of the difficulties of monitoring the mandatory provision of screening, diagnosis and treatment service to eligible medically needy children, the penalty provision will be limited to services to children in cash assistance families. However, medically needy children are entitled to these services, and States have an obligation to provide them in accordance with the law and regulations.

Although the penalty for noncompliance by States with the child health screening and treatment regulation would not become effective until July 1, 1975, States will be expected to have health screening and treatment programs for eligible children under age 21 by July 1, 1973, as required by medicaid regulation.

Care and Treatment for Drug Addicts and Alcoholics

(Sec. 299G of the bill)

Background

Federal statutes and legislative history are silent in terms of specific references concerning the eligibility of alcoholics and drug addicts, on account of these diseases, for public assistance under the program of Aid to the Totally and Permanently Disabled (APTD). However, the Department of Health, Education, and Welfare has ruled that otherwise eligible persons whose primary disabling condition was alcoholism or addiction could be classified at the option of a State as eligible for APTD.

In June 1970, some 12,000 APTD recipients were classified as disabled with a primary diagnosis of alcoholism. The Department of Health, Education, and Welfare estimates, in general terms, that, nationwide, under the HEW ruling approximately 200,000 alcoholics are potentially eligible for APTD because of low income and assets. Also, based upon Department of Health, Education, and Welfare data, as many as 200,000 drug addicts may be eligible or potentially eligible for APTD because of low income and assets.

APTD recipients are eligible for cash maintenance payments, medicaid and social services. A recent Department of Health, Education, and Welfare agreement with the State of New York resulted in the definition of social services for addicts being broadened to include many medical services. This agreement resulted in increased Federal funds for New York because social services receive 75 percent Federal

84-378 O - 72 - 9

matching, whereas medicaid services in New York are matched at only 50 percent. In addition many services which previously had not been considered eligible for Federal matching were reclassified as social services and now qualify for 75 percent Federal matching.

House Bill

Under the House bill, alcoholics and addicts meeting the definition of disability would not receive cash assistance if treatment were available which they refused. The House bill did not provide any mechanisms for assuring the care and treatment of those addicts and alcoholics on welfare.

Committee Concern

The Finance Committee is concerned that this provision might result, in many cases, in alcoholics and addicts receiving cash payments without being involved—or while only being nominally involved—in treatment programs. Related to this is the obvious problem of alcoholics and addicts using welfare payments to support their addiction or alcoholism. By the nature of their illness, alcoholics and addicts might well use cash assistance to support their alcoholism or addiction rather than for the purposes for which it was provided.

Committee Provision

The committee has therefore approved an amendment precluding eligibility of medically determined alcoholics and addicts for welfare under the program of Aid to Families With Dependent Children (AFDC) and for benefits, on the basis of disability, under the Supplemental Security Income program. Thus addicts and alcoholics may not be eligible for income maintenance under AFDC and the Supplemental Security Income program in the future. Instead the committee bill would establish a program under title XV of the Social Security Act designed to encourage appropriate care and treatment of alcoholics and addicts.

The committee amendment provides that alcoholics and addicts who are otherwise eligible for AFDC, in a State (in terms of residency, income and resources) or for Supplemental Security Income and who also meet a definition of eligibility parellel to the social security program's definition, that is, who are unable to engage in any substantial gainful activity (regardless of whether required to engage in such activity) by reason of a medically determinable (by a physician qualified to make such determinations) addictive dependence upon drugs or alcohol which has lasted or can be expected to last for a period of 12 months or more—would be eligible to receive help through an alcoholism and/or addiction treatment program which would be established under title XV, if the State chooses to institute such a program.

Recent Federal legislation, particularly the Alcohol Abuse and Treatment Act of 1970 and the Drug Abuse Office and Treatment Act of 1972, defined a broad expanded Federal role in dealing with problems of alcoholism and addiction. The Comprehensive Alcohol Abuse and Alcoholism Treatment Act authorized the establishment of the National Institute on Alcohol Abuse and Alcoholism to develop and conduct comprehensive programs of research, and control of alcohol

abuse and alcoholism. The Drug Abuse Office and Treatment Act of 1972 (approved March 21) expanded existing programs for the control of drug abuse and provided for the coordination of all Federal efforts relating to drug abuse, treatment, education and research. Each statute also authorized a new formula grant program for assistance to States in planning, establishing, maintaining, coordinating and evaluating alcoholism and drugs abuse projects, respectively. In order to qualify for the formula grants under either Act, a State must submit a plan for attaining the goals of each program and must designate or establish a single State agency for preparation and administration of each plan. To date, all States have an active State agency designated pursuant to the provisions of the Alcoholism Treatment Act. A majority of the States have an agency which would meet the statutory requirements of the Drug Abuse Treatment Act, and all fifty have some agency charged with coordinating current efforts to control drug abuse.

In order to coordinate the new title XV program with these recently established drug and alcohol abuse treatment programs, title XV funds would be made available only to local treatment agencies, institutions, practitioners, and organizations which are certified to be appropriate and qualified to provide such care and treatment by the designated State drug or alcohol abuse and treatment agency. Once enrolled in the title XV treatment program, the alcoholic or addict would be referred to a local treatment organization or agency. There would be no independent separate programs of care and treatment for the alcoholics and addicts under the welfare laws.

To be eligible for reimbursement under title XV, the individual treatment program must be carried out under a professionally developed plan for rehabilitation designed to terminate dysfunctional dependency upon alcohol or drugs. The rehabilitation plan must be reviewed (and modified as necessary) at three month intervals in order to formally evaluate the adequacy and continued necessity of the care and treatment. However, to assure continuity of necessary care and treatment, the initial medical determination of addiction or alcoholism could be deemed valid for up to 12 months. Additionally, this review requirement is intended to guard against pro forma application of the rehabilitation plan. The plan of treatment must include to the maximum extent feasible work rehabilitation. Authorities in treatment and rehabilitation of alcoholics and addicts have strongly emphasized the importance of work therapy as part of a comprehensive plan of rehabilitation and the committee bill incorporates this desirable feature.

Further, the Secretary and the Inspector General would be required to regularly determine that pro forma compliance was not being undertaken. Federal matching funds would be automatically terminated for medically determined alcoholics and addicts not involved in an active program.

In a State which provides assistance under Aid to Families with Dependent Children, to persons medically determined to be alcoholics or addicts, such persons would have to be referred for care and treatment to the Title XV agency as a condition of continued eligibility for Federal matching. Refusal of care and treatment by an addict or

alcoholic would result in termination of assistance payments and medicaid for that individual.

Similarly, in States which do not opt to establish a title XV program, alcoholics and addicts will not be eligible for any federally matched cash assistance payments. The same conditions apply to addicts and alcoholics eligible for benefit under the supplemental income program on the basis of a disability.

Maintenance of Fiscal Effort

To assure maintenance of expenditure levels in the primary Federal and State programs directed toward treatment and rehabilitation of alcoholics and addicts, and to avoid any shifting of those expenditures to title XV, the amendment would provide that: If a reduction in Federal, State, or local expenditures is made, either through reduction in appropriations or expenditure levels (including impounding of appropriated funds), then the Federal matching funds available under title XV would be reduced proportionate to the other decreases.

Funds spent under the program for supportive assistance payments and medicaid payments to persons otherwise eligible for those payments and services under a State plan (and who are receiving care and treatment under title XV) would be excluded from the amount determined to be spent for care and treatment for purposes of calculating levels of fiscal effort.

The Finance Committee is also concerned that some States have circumvented the intent of present law in efforts to obtain higher Federal matching for services to rehabilitate alcoholics and addicts. Services which are health related should be reimbursed under the medicaid matching rates and not as social services. The committee amendment provides that matching under title XV would be at the rates otherwise provided for the types of payments made. For example, medical care and treatment would be matched at the medicaid rates and cash payments and defined social services would be matched or otherwise financed at the rate applicable to the category under which the person would otherwise be aided.

To the extent that at least 50 percent of medically determined alcoholics and addicts are not enrolled and receiving active care and treatment under title XV within 6 months of enactment of the amendment States would lose Federal matching for those not in treatment; similiarly at least 75 percent must be enrolled and in treatment within 9 months and all such persons brought into title XV by the end of 12 months.

Supportive Assistance for Alcoholics and Addicts

As described, the committee amendment makes medically determined alcoholics and addicts ineligible for payments under the AFDC program and the supplemental income program. Owing to the nature of their illnesses, alcoholics and addicts might well use these payments to support their alcoholism or addiction rather than for the purposes for which the assistance was provided.

The committee's concern is shared by many individuals and agencies active in the treatment of alcoholics and addicts. For example, in a

recent letter to the committee, the Association of Voluntary Agencies on Narcotics Treatment, Inc (AVANT) of New York stated:

> "The tragedy in New York and other major cities is that there are not enough treatment facilities like the member agencies of AVANT. Welfare officials claim they frequently approve welfare payments to addicts not in treatment because the addicts in question cannot get into crowded treatment programs. These officials naively ignore the fact that the addicts will immediately use the money for drugs."
>
> "The solution to this dilemma is not to keep dispensing more money * * * but to provide more treatment facilities and to enact stronger legislation requiring abusers of all illicit drugs to undergo treatment."

It is recognized that, in some cases, the plan of proper treatment or rehabilitation could be furthered with protective payments for the enrolled alcoholic or addict's needs with respect to food, clothing and shelter. Therefore, the committee amendment provides that in those specific cases where it is determined that proper treatment or rehabilitation would be aided by protective assistance payments, such assistance could be granted in a fashion which would support the treatment activities, but only to persons otherwise eligible in a State for aid or assistance (except for their medically determined alcoholism or drug addiction). To the extent that an enrollee received food, clothing and shelter in an institutional or other setting, protective payment amounts, if any, would be adjusted accordingly. At certain stages of treatment, it is conceivable that supportive payments could be made (in whole or part) directly to the enrollee where those in charge of his treatment determine that direct support would enhance rehabilitation and further capacity for independent living. The amendment authorizes exceptions, in such cases, to the protective payments approach. The determination as to whether protective payments are necessary to support the treatment plan would have to be specifically reevaluated at least every three months. Such payments could be no greater than comparable payments under the appropriate cash program and would be made by the title XV agency. Authorization as to payments and frequencies thereof, would usually be based upon the recommendation of the local treatment program.

Payments would come from funds for the cash program for which the person would otherwise be eligible.

Modification of the Role of the Health Insurance Benefits Advisory Council

(Sec. 288 of the bill)

The Health Insurance Benefits Advisory Council (HIBAC), established under the 1965 Social Security Amendments, advises the Secretary of Health, Education, and Welfare on matters of general policy in the administration of the medicare program, including the formulation of regulations. The 1967 amendments expanded the functions of the Council to include the responsibility for reviewing and reporting to the Congress on the effectiveness of the medicare program and on

possible improvements in the administration of the program and in the law itself.

In keeping with its concern that the proliferation of advisory bodies in HEW be periodically evaluated, the committee has found that the need for and role of the Health Insurance Benefits Advisory Council have substantially changed since the initiation of medicare. During the formative years of medicare there was some advantage to having a group such as HIBAC, broadly representative of the major health care interests, to review and offer recommendations to the Secretary on the formulation of a large body of regulations and program policies. However, much of that work is now completed, and there seems little need for permanent authority to deal with the often routine modifications and refinements in medicare in view of the program's present status and the development of administrative expertise and capabilities. The National Professional Standards Review Council, which would be established under the PSRO amendment previously approved by the Committee, would undertake functions with respect to evaluation of utilization of health care services presently part of HIBAC's charge.

The present status of medicare would seem to require different kinds of advice from outside advisors. During the initial years of the program, advisory bodies broadly representative of the major health care interests were a source of information about the possible reactions of their constituencies to proposed policies and regulations. Now that the major policy features of the program have been established and additional formal and informal lines of communication with the major interests set up, there is a decreased need for such advice. For example, the Department has established formal consultation procedures with medicare carriers and intermediaries to deal with operational problems related to the claims process.

The committee has, therefore, added to the House-approved bill a provision that modifies the role of the Health Insurance Benefits Advisory Council so that its role would be that of offering suggestions for the consideration of the Secretary on matters of general policy in the medicare and medicaid programs.

Durable Medical Equipment

(Sec. 245 of the bill)

Present law provides for reimbursement under part B of the medicare program for expenses incurred for the rental or purchase of durable medical equipment used in the patient's home. The beneficiary has the option to rent or purchase such equipment. In the case of purchase, medicare reimbursement is generally made in monthly installments equivalent to amounts that would have been paid had the equipment been rented. Payments continue for as long as the equipment is medically required by the individual's condition or until the total of the monthly installments paid equals 80 percent of the reasonable purchase price less an applicable portion of the deductible, whichever comes first. Payment in the case of the purchase of inexpensive equipment (presently defined as equipment for which the reasonable

charge is $50 or less) may be made in a lump sum if such method of payment is less costly or more practical than periodic payment.

Where the beneficiary elects to rent, the program is bound to continue indemnifying him for his rental expenses as long as his medical need for the item continues. Extensive review by the General Accounting Office showed that rental payments for durable medical equipment often exceed the purchase price. Where it is reasonably predictable that rental cost would exceed the cost of purchase but the equipment is nevertheless rented, the rental provision may impose unreasonable expenses on the program.

The committee has added to the House bill a provision to help avoid unreasonable expenses to the program which result from prolonged rentals of durable medical equipment. The Secretary of Health, Education, and Welfare would be authorized to experiment with reimbursement approaches (in various geographic areas) which are intended to prevent these unreasonable expenses and to implement without further legislation any purchase approach found to be workable, desirable, and economical. The committee suggests that among the possible approaches to be evaluated would be the feasibility of suppliers contracting with the Secretary of Health, Education, and Welfare under arrangements whereby rental would be undertaken by means of lease-purchase arrangements which provided for rental payments to terminate when an agreed-upon total for purchase was reached; under another approach, medicare payment for a covered item of durable medical equipment would be made to the supplier in a lump sum where it was determined, in accordance with guidelines of the Secretary, that outright purchase would probably be more economical than lease-purchase; another approach would be to encourage beneficiaries to purchase used equipment by waiving the present 20-percent-coinsurance requirement where the purchase price of the used equipment was at least 25 percent less than the reasonable price of new equipment.

Disclosure of Information Concerning the Performance of Carriers, Intermediaries, State Agencies, and Providers Under Medicare and Medicaid

(Sec. 249C of the bill)

As part of his responsibility for administration of the medicare program, the Secretary, through the Social Security Administration regularly prepares formal evaluations of the performance of contractors—carriers, intermediaries and State agencies—which assist in program administration. In addition the Social Security Administration prepares program validation review reports, which are used as management and audit devices for informing intermediaries of findings and recommendations concerning selected providers of services and some of the aspects of their own medicare operations and of indicating necessary corrective follow-up action with respect to both the provider as well as the intermediary.

These evaluations and reports are of significant help in reviewing either the overall administrative performance of an individual con-

tractor or a particular aspect of its operation. Additionally, the summary evaluations comparing the performance of one contractor with that of another are very useful. However, these evaluations and reports are not available to the public in general.

The committee recognizes the dilemma which exists in this situation. On the one hand is the need for public awareness of the deficiencies of contractors and provider performance with the accompanying pressures for improvement in administration that only such awareness can bring as well as the desire to conform with the overall intent of the Freedom of Information Act. On the other hand, these evaluations and reports require review of details some of which do not provide a basis for conclusion as to overall performance and the initial evaluation may not always be based on all the pertinent facts. The possible release of portions of a report which may include unqualified or incomplete information may be unfair to the contractors or providers. The committee recognizes that when there is public disclosure of this type of information on contractor performance there is a need to provide contractors with sufficient opportunity to respond to the information in the reports before their publication so as to avoid release of possibly erroneous findings, without rebuttal, which might prove damaging to their reputation.

The committee bill would require that the Secretary make public the following types of evaluations and reports dealing with the operation of the medicare and medicaid programs: (1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies, including the reports of followup reviews; (2) comparative evaluations of the performance of contractors—including comparisons of either overall performance or of any particular contractor operation; (3) program validation survey reports—with the names of individuals deleted.

The bill would require prompt and timely public disclosure of reports prepared by the Secretary and submitted to any contractor or provider of services for review and comment after the third month following enactment. Such reports would include only those which are official in nature and would not include internal working documents such as informal memoranda. Under the bill, public disclosure of evaluations and reports would not be required to be made until the contractor, State agency, or facility was given suitable opportunity—not to exceed 60 days—for comments as to the accuracy of the findings and conclusions of the evaluation or report with such comments being made part of the report where the portions originally objected to have not been modified in line with the comment. The reports would not be required to contain information concerning those deficiencies which are known by the Secretary to have been fully corrected within 60 days of the date they were initially brought to the attention of the contractor or provider of services.

It is the committee's intent that the requirement of disclosure of such evaluations and reports not lessen the effort of the Secretary in his present information-gathering activities nor is the provision in any way to be interpreted as otherwise limiting any disclosure of information otherwise required under the Freedom of Information Act.

Requirement for States To Deem Eligible for Medicaid Those Assistance Recipients Who Would Lose Eligibility Because of 20-percent Social Security Increase

(Sec. 249D of the bill)

The Congress recently passed legislation (Public Law 92–336) providing a 20 percent increase in social security benefits effective September 1, 1972. As a result of this increase an estimated 190,000 aged, blind, and disabled persons will lose their eligibility for cash assistance and will be moved off the cash assistance rolls. Approximately half of these persons reside in States which have no medically needy program. Their loss of cash assistance eligibility will therefore preclude them from receiving any medicaid coverage.

Persons residing in States with medically needy programs who are removed from the cash assistance rolls are insured against permanent loss of medicaid eligibility. In these States, categorically related individuals may lose their medicaid coverage if their income resources exceed the State's eligibility standards for medicaid, but they may regain coverage after having incurred medical costs equal to the amount by which their income exceeds the standard. This is the so-called "spend-down" feature.

Title XIX requires States with a medically needy program to disregard in determining income all expenses incurred by an individual for medical and remedial care recognized under State law in the process of determining an individual's eligibility for medicaid. This provides a limit on the medical costs a person must absorb from his own income before he is eligible to receive assistance under medicaid. Thus, while under present law the social security benefit increase could result in a loss of medicaid coverage in those States for cash assistance recipients who are receiving assistance in an amount less than their social security benefit increase, these categorically related individuals could regain medicaid coverage after "spending down" a specified amount of their income on covered medical care. In States without programs covering the medically needy, however, persons who lose their medicaid eligibility because of the increase in social security benefits have no similar recourse. When they lose their cash assistance, they lose all opportunity for medicaid coverage no matter how high their medical bills or how pressing their medical needs.

The committee is particularly concerned that the recently passed social security benefit increase should not force formerly eligible individuals to lose all medicaid coverage. It has therefore included a provision in the bill which would require that in those States which limit medicaid coverage to categorically needy persons (recipients of cash assistance or persons who would be eligible for cash payments except that they reside in an institution), no person who was medicaid-eligible in August 1972 could be deemed ineligible for medicaid solely because of the increase in income resulting from the 20 percent increase in social security benefits voted by the Congress in June 1972. In implementing this provision, a State may have the option of requiring a person who leaves the cash rolls because of the social security

increase to incur medical expenses in the amount of the excess income resulting from the benefit change before he receives medicaid coverage (in effect, instituting for these persons a spend-down similar to that applied in States with programs for the medically needy). Alternately, a State may simply disregard that amount of the social security benefit increase by which income exceeds the standard for purposes of determining medicaid eligibility. Such a disregard would not be applicable for purposes of the cash assistance program.

The committee has included this amendment to prevent total loss of medicaid coverage to individuals who lose eligibility as a result of the recently enacted increase. This amendment will not preclude persons, residing in medically needy States, from losing their eligibility as categorically needy persons and becoming medically needy (subject to State requirements including the spend-down provision).

Preventing Payment for Institutional Health Care Under the Cash Welfare Programs to Avoid Compliance With Medicaid Standards

(Sec. 249(E) of the bill)

Under present law (Section 121(b) of Public Law 89–97), no Federal matching payment may be made to any State under the cash assistance programs with respect to "aid or assistance in the form of medical or any other type of remedial care" for any period for which States receive title XIX payments or for any period after December 31, 1969. The Department has restricted application of the 1965 provision to prohibit only vendor payments for medical or remedial care. States therefore have the option of including the cost of medical service in the cash welfare payment to recipients. To date, States have had little incentive to use this cash grant method of payment, although there is evidence that some States have used this device to avoid application of medicaid standards to some substandard nursing homes and intermediate care facilities.

The Department of Health, Education, and Welfare is currently engaged in efforts to strengthen enforcement of skilled nursing home and extended care facility standards in accordance with statutory requirements. With the recent transfer of the administration of intermediate care facilities to the title XIX program, Federal efforts have also been directed toward development and enforcement of standards and statutory requirements for these facilities. The committee has included a number of important provisions designed to upgrade long-term care services and facilities and strengthen the Federal Government's enforcement activities. The combination of these efforts will require a large number of facilities, currently receiving title XIX matching funds, to make substantial improvements in order to remain eligible providers.

The committee is concerned that a number of substandard skilled nursing facilities and intermediate care facilities may seek to avoid the burden of correcting their deficiencies. Under current practice, they could withdraw from the medicaid program and possibly force the State agency to continue the support of patients in these homes by adding the cost of care to the patients' monthly welfare payments.

The committee has therefore included a provision to preclude Federal matching for that portion of any money payment which is related to institutional, medical, remedial or other care which is (or could be) included under the medicaid program. The thrust of this provision is to bar using the cash grant system to finance nursing facility care and services in intermediate care facilities as a means of avoiding application of title XIX standards for facilities providing these services. It is not expected to relate to other title XIX services—such as dental care or prescription drugs—which are generally not delivered in an institutional setting (except to the extent such services are defined by the Secretary to be an essential part of skilled nursing facility or intermediate care facility services).

A facility providing care which in general resembles or is similar to that provided under medicaid but which fails to meet Federal requiments could not seek to circumvent application of this provision with the claim that since it did not meet title XIX standards and was not a title XIX facility, its services could not be considered title XIX services and were therefore not subject to this restriction. Any cash recipient receiving care in an institution which could, if it upgraded its services or facilities, be an eligible provider would be precluded from receiving Federal matching for that portion of his payment which is related to institutional, medical, remedial, or similar care. States would continue to receive Federal matching for payments to persons to finance the cost of room and board in the case of recipients who require no health related services beyond room and board. In determining whether cash grant payments for institutional care were being used to subvert the intent of this provision, however, it is expected that the Department would carefully examine the amount of payment included for the purchase of room and board and compare it to amounts expended for title XIX institutional care; a significant differential in the amount of this payment and the average payments for ICF or skilled nursing home care would be expected. In addition, the State would have an obligation to demonstrate to the satisfaction of the Secretary that persons residing in an institutional setting, financed through the cash grant program (1) were not receiving intermediate care facility services or skilled nursing home care and (2) were not in need of such services—i.e., were appropriately placed in such facilities.

Conditions of Coverage of Outpatient Speech Pathology

(Sec. 283 of the bill)

At present, speech therapy services are covered under medicare when provided by approved hospitals (on both an inpatient and outpatient basis) or home health agencies. The services may be provided by an employee of the provider or by an outside source (agency, clinic, or independent practitioner) under contract to the provider. Speech therapy services are also covered under part B as incident to physician services, provided they are furnished under the direct supervision of the physician.

While speech pathology services are generally useful to aged persons with certain disorders, such services are sometimes unavailable to the

aged due to the small percentage of speech pathologists who are employed by providers eligible to participate in the medicare program. Part of the problem is the fact that the outpatient services must be provided under the direct supervision of a physician.

The committee has approved an amendment providing that medicare part B coverage include speech pathology services—the same services now covered as speech therapy when furnished as a provider service—furnished to beneficiaries on an outpatient basis by organized agencies, clinics or other health centers without necessarily requiring direct physician supervision of such services. Generally, an organized setting would be one in which two or more qualified practitioners are furnishing covered services. Providers would be required to meet conditions established by the Secretary to assure proper coordination, continuity, and quality of care. Individuals should continue as under present law, to be referred by a physician for services furnished by or under the direct supervision of a qualified speech therapist, under a plan for the individual's total care, established and periodically reviewed by the physician who retains overall responsibility for the individual's care. Reimbursement for services would be made to the agency, clinic, or center on the basis of reasonable cost. The amendment would be effective with respect to services furnished after December 31, 1972.

Conditions of Coverage of Services of Clinical Psychologists

(Sec. 284 of the bill)

Coverage of the services of clinical psychologists is presently available on a basis which includes a requirement that the services of such psychologists must be provided as part of hospital or extended care services or under direct physician supervision.

The requirement that outpatient services of such psychologists be rendered under direct physician supervision apparently restricts the availability of such services to the elderly as there are many psychological clinics which are not physician-directed.

The committee has approved an amendment which would liberalize the coverage provision under part B limiting coverage of outpatient services of a clinical psychologist to those provided under direct physician supervision retaining, however, the other requirements of present law as well as those additional general requirements described with respect to broader coverage of speech therapy including that which would require an organized setting to be one in which two or more qualified practitioners are furnishing covered services. Additionally, with respect to psychological treatment, such costs would be included in and limited by the overall $250 annual limitation on outpatient treatment of mental illness, as they are under present law when furnished by physicians. The amendment would be effective with respect to services furnished after December 31, 1972.

Coverage of Podiatric Residents and Interns

(Sec. 276 of the bill)

The Social Security Amendments of 1967 amended the medicare definition of "physician" to include podiatrists. However, no change

was made in the definition of "approved" teaching programs in hospitals, which include the intern and residency programs of other medicare "physician" professionals. (Services provided to hospital inpatients by participants in such approved teaching programs are reimbursable on a cost basis under the hospital insurance program.) The committee bill would remove this anomaly by including within the definition of approved teaching programs the services furnished by an intern or resident-in-training in the field of podiatry under a teaching program approved by the Council on Podiatry Education of the American Podiatry Association.

This provision would be effective with respect to accounting periods beginning after December 31, 1972.

Outpatient Rehabilitation Coverage

(Sec. 285 of the bill)

Medicare beneficiaries who are not inpatients of hospitals or extended care facilities, or homebound and entitled to home health services, have limited access to certain restorative and rehabilitative services. While part B of medicare presently covers outpatient physical therapy services furnished by providers of services, including clinics, rehabilitation agencies, and public health agencies, similar coverage for rehabilitation services which are useful to older people is not provided in certain types of settings under present law. Thus, medicare payment cannot be made for services furnished by free-standing rehabilitation facilities which provide a range of rehabilitation services on an outpatient basis which would be covered under existing law if they were provided by participating home health agencies or by hospital outpatient departments. The committee has therefore included an amendment so that, with appropriate assurances of quality of care, safety of the patient, and reasonable costs, such services would be more accessible to beneficiaries.

The committee bill establishes a new benefit category which would permit reimbursement under part B for outpatient rehabilitation furnished in organized settings. The new benefit would cover physical therapy, speech pathology, occupational therapy, and medical social services, provided on an outpatient basis by qualified outpatient rehabilitation facilities including providers of services, clinics, rehabilitation agencies, and public health agencies. A physician would have to certify that the services are required by an individual who needs physical therapy or speech pathology services and the services must be furnished in accordance with a plan established and periodically reviewed by a physician. The plan would prescribe the specific types of rehabilitation services to be provided and the amount and duration of such services.

The requirements that organizations must meet in order to provide the new outpatient rehabilitation benefit would be similar to the types of standards now imposed on providers of outpatient physical therapy services. These requirements are intended to assure that only health care of proper quality will be paid for. The facility would be required to satisfy conditions relating to medical records, policies governing the services provided, and State or applicable local licensing

84-378 O - 72 - 10

requirements. The facility would also have to be organized so as to provide an adequate outpatient rehabilitation program for the services which it is certified to provide. This would include a requirement that they have adequate physician participation to the extent necessary to assure that the services provided are both efficient and properly related to the total medical needs of the patient. In addition, the facility would have to meet such other conditions relating to health and safety as the Secretary may find necessary.

Payments for outpatient rehabilitation services will be on the basis of reasonable costs as is now done for services furnished by other participating providers of services. For purposes of administration, it is expected that payment for outpatient rehabilitation services provided by approved facilities or by others under arrangements with them, would be handled by organizations serving as fiscal intermediaries under part A of the program. In effect, approved clinics and agencies would be treated as "providers of services" for purposes of facilitating payment for outpatient rehabilitation services and as such would have to agree not to charge any beneficiary for covered services for which payment would be made under the program and to make adequate provision for refund of erroneous charges.

The committee bill would extend the provisions of present law under which State agencies, operating under agreements with the Secretary, determine whether a provider of services meets the conditions for participation in the health insurance program, to provide that State agencies would also determine whether an outpatient rehabilitation facility meets the appropriate requirements.

The committee does not intend that outpatient rehabilitation coverage will be utilized to meet the needs of individuals whose problems are not primarily related to health care. The committee expects that the Secretary will take appropriate measures to assure that program reimbursement will be made only for services furnished to an individual who requires skilled professional services which are reasonable and necessary for the diagnosis or treatment of an illness or injury. Should the Secretary's review of payments made for outpatient rehabilitation services reveal abuses or improper utilization of such services which the statute cannot help him curb, it is expected that he will report such problems in his annual report to the Congress.

Benefits would be payable for covered outpatient rehabilitation services furnished beginning January 1, 1973.

Authority of Secretary To Select Intermediaries and Assign Providers to Them

(Sec. 286 of the bill)

Under present law, a group or association of providers of services—hospitals, extended care facilities, and home health agencies—have the option of nominating an organization or agency to act as the "fiscal intermediary" between the providers and the Secretary of Health, Education, and Welfare. The Secretary is authorized to enter into an agreement which provides for the organization or agency to determine amounts due the providers. Any provider which either elects not to be bound by the group's nomination of an intermediary or is not a member of a group making such a nomination, may elect to be paid through

any organization or agency which has entered into an agreement with the Secretary, if the Secretary and the organization agree to it, or the provider may elect to deal directly with the Secretary. The Secretary may enter into an agreement with an organization or agency to act as a "fiscal intermediary" only if he finds that to do so would be consistent with effective and efficient administration of the program.

An agreement may be terminated by the intermediary or by the Secretary, with appropriate notice. The Secretary may terminate an agreement with an intermediary only if he finds that it has failed to carry out the agreement or that continuation of the agreement is inconsistent with efficient administration of the program.

The arrangement under present law giving providers of services wide latitude in their choice of intermediaries was appropriate at the outset of the medicare program. As the program has matured, however, such unrestricted choice may be an impediment to efficient and economical administration. For example, where an intermediary is selected by only a small minority of providers in an area, it is very difficult for the intermediary to perform the cost comparisons and other analyses which are an essential component of determinations of reasonable costs. Unrestricted choice of intermediaries also raises the possibility that a provider will "shop" for the most lenient fiscal intermediary. Moreover, unrestricted choice interferes with the Administration's efforts to improve program administration by increasing the responsibilities of the most efficient intermediaries, while decreasing the roles of relatively inefficient intermediaries.

Accordingly, administrative prerogatives in the assignment of new providers to intermediaries and the reassignment of existing providers should be strengthened. The Secretary should have the primary authority to determine to which intermediary providers may be assigned or reassigned when they wish to change intermediaries or where continued availability of a particular intermediary (or direct payment by the Secretary) in a given locale is inefficient, ineffective, or otherwise not in the best interests of the program. The Secretary should consider the preference of the provider, but should also be able to take a different course of action in the interest of effective program operation.

The committee bill would authorize the Secretary to assign or reassign providers to available intermediaries or to require that payments to a given provider be made directly by the Secretary in any case where such assignment or reassignment would result in more effective and efficient administration of the medicare program.

This provision would become effective on January 1, 1973.

Limitations on Adjustment or Recovery of Incorrect Payments Under the Medicare Program

(Sec. 281 of the bill)

Under present law, the Secretary is required to recover overpayments made to or on behalf of an individual where it is determined that services for which payment has been made were not covered under medicare. Further, present law provides that overpayments made to providers or other persons for services furnished an individual,

which cannot be recovered from the overpaid provider of services or other person, may be recovered by decreasing subsequent payments to which an individual is entitled under title II of the Act.

Present law also provides that adjustment or recovery of an incorrect payment will not be made with respect to an individual who is without fault and where such an adjustment (or recovery) would defeat the purposes of title II or would be against equity and good conscience. However, there are no similar provisions specifically authorizing the application of waiver with respect to providers of services and other overpaid persons. While the Administration has developed guidelines to specify the situations where a provider of services or other person should not be held responsible for repayment of incorrect amounts, the committee has added provisions to apply where it seems inequitable to recover from a provider or the individual.

The committee is particularly concerned about overpayments discovered long after the payment was made. It has therefore, included an amendment providing that, after 3 years have expired, there will be a presumption, in the absence of evidence to the contrary, that the provider or other person shall be deemed to be without fault with respect to an overpayment and that under such circumstances no collection should be made. However, the Secretary would be authorized to make the presumption before the 3 years have expired (but not before 1 year) if he finds that to do so would be consistent with the objectives of title XVIII.

The amendment also requires that providers under their participation agreements (or physicians or other persons where they have accepted assignments) where collection of an overpayment is made from the provider or others, be prohibited, after 3 years, from charging beneficiaries for services found by the Secretary to be medically unnecessary or custodial in nature, in the absence of fault on the part of the individual who received the services. However, the Secretary would be authorized to make the presumption before the 3 years have expired (but not before 1 year) if he finds that to do so would be consistent with the objectives of title XVIII.

Additionally, the Secretary would be authorized to deny claims for reimbursement made after the lapse of a reasonable period of time specified by him in regulation, of not less than 1 year nor more than 3 years. This provision is similar to one developed by the committee in 1970 and included in H.R. 17550 as passed by the Senate.

The limit on right of recovery would apply to notices of payment after 1968. The limit on filing claims would apply to requests for payment made after 1970.

14-Day Transfer Requirement for Extended Care Benefits

(Sec. 248 of the bill)

Under present law, medicare beneficiaries are entitled to extended care benefits only if they are transferred to a skilled nursing facility within 14 days of discharge from a hospital. The committee added to the House bill a provision which would modify this requirement in certain defined cases where failure to begin receiving extended care services within 14 days would not change the nature of the services as

a continuation of treatment begun in the hospital. Intervals of more than 14 days would be permitted when, following discharge from a hospital, the patient's condition did not permit immediate provision of skilled nursing or rehabilitation services, or the nonavailability of appropriate bed space in facilities ordinarily utilized in the geographic area prevented admission for not longer than 2 weeks beyond the 14 days. The Secretary would define in regulations the criteria to be applied in determining whether the 14-day requirement can be waived.

One example of the type of situation intended to be covered is a patient with a fractured hip who may require little in the way of skilled care for some time after his discharge from the hospital because the fracture will not have mended to the point where physical therapy and restorative nursing can be utilized. In such a case, regulations could indicate that payment of posthospital extended care benefits would start when the patient begins an active program of skilled care, even though more than 14 days will have elapsed since his transfer from the hospital, since such care would be clearly related to his hospitalization. Another example would be the case where an individual was discharged from a hospital to his home rather than to a skilled facility because no bed was available and the person's illness required the use of private duty nursing on an essentially full-time basis to provide skilled care. A third example would be a person who needed daily skilled services and went home because no bed was available but lack of funds or appropriate services prevented him from receiving daily skilled care at home and the health of the patient suffered. The cost of this change would not be significant.

Consultants for Skilled Care Facilities

(Sec. 277 of the bill)

Among the conditions of participation for extended care facilities in the medicare program is the requirement that these facilities retain consultants in specialty areas such as the maintenance of medical records and the formulation of policies governing the provision of dietary and social services. Reimbursement is made to each facility only for that portion of the costs of the consultants' services representing services provided to medicare patients. For example, if 20 percent of the patient days in an extended care facility are medicare and the remaining 80 percent are medicaid patient days, the facility can recover only 20 percent of the costs of the consultants' services from the medicare program. The remaining 80 percent of the cost must come from the fixed per diem payment made by the State for medicaid patients.

The committee is aware that in many parts of the country consultants in these particular specialty areas are in short supply, competition for their services is intense, and the cost of retaining them on a per diem basis is often prohibitive for many extended care facilities. In some cases, the difficulty encountered by an extended care facility in retaining and paying for a consultant is compounded by the fact that a large number of the facility's patients are on medicaid. Often the State has provided similar consultative services for these medicaid patients, and no additional medicaid allowance can be made for the

outside consultants employed to meet the medicare conditions of participation.

Under the committee bill those State agencies that are able and willing to provide these specialized consultative services for medicare patients in an extended care facility which requests them, would be authorized to do so, subject to approval of the State's arrangements by the Secretary. The provision of consultative services by the State agency on this basis would satisfy the medicare requirements relating to the use of consultants in the appropriate specialty areas. Payment by medicare would be made directly to the State agency for the costs incurred in rendering the consultative services. The State agency would be authorized to limit the availability of these services, consistent with its own assessment of available resources and needs.

This approach is in reality an extension of present responsibilities, since State agencies have had a consultative as well as a certifying role in medicare.

The amendment should result in lower costs to the medicare program as the consultants would be salaried employees of the State. It should also lead to more effective use of scarce personnel. Finally, determination of compliance by a facility with the required consultative services would be substantially simplified through verification at a single source—the State agency—rather than with a multiplicity of individual and scattered consultants.

A similar provision was approved by the committee in 1970 and included in H.R. 17550 as passed by the Senate in 1970.

Direct Laboratory Billing of Patients

(Sec. 279 of the bill)

Payment under medicare for low cost diagnostic laboratory tests covered under the supplementary medical insurance program presents a problem when patients are billed directly for such services by the laboratory and assign their claims for medicare payment of a portion of the cost to the laboratory. The problem is that the cost of collection of an individual bill is large compared with the amount of the bill, particularly with respect to collection of the coinsurance portion. For example, where a bill for a laboratory service is $1.50, medicare will pay only 80 percent, or $1.20, and the laboratory must bill the patient for the 30 cents coinsurance for which he is responsible. The cost to the laboratory of billing may exceed 30 cents, a situation which might result in the laboratory raising its fee for such service to $2.00, so that it could collect its full charge from medicare without billing the patient for the coinsurance.

The committee therefore added a provision to the House bill, with respect to diagnostic laboratory tests for which payment is to be made to the laboratory, so that the Secretary would be authorized to negotiate a payment rate with the laboratory which would be considered the full charge for such tests, for which reimbursement would be made at 100 percent of such negotiated rate. However, such negotiated rate would be limited to an amount not to exceed the total payment that would have been made in the absence of such rate.

Authority of Secretary to Administer Oaths in Medicare Proceedings

(Sec. 289 of the bill)

Under present law, the Social Security Administration has the right to take affidavits under oath from beneficiaries, other witnesses, and principals in cases involving fraud, but only with respect to instances involving cash or disability insurance benefits (under title II of the Social Security Act). There is no provision in title XVIII which grants the same right with respect to cases involving the medicare program.

As a result, the Social Security Administration personnel have been limited in their investigations of suspected program abuses because they may obtain only statements from claimants and other persons involved in potential fraud cases, as opposed to affirmations under oath. Witnesses are less likely to change their testimony at the time of trial if an affidavit is originally taken, since they generally attach more legal significance to such an affidavit as opposed to a statement completed on an administrative form.

The committee bill therefore includes a provision which would authorize the Secretary, in carrying out his responsibility for administration of the medicare program, to administer oaths and affirmations in the course of any hearing, investigation, or other proceeding.

Termination of Medical Assistance Advisory Council

(Sec. 287 of the bill)

The 1967 Social Security Amendments established a 21-member Medical Assistance Advisory Committee (MAAC) for the purpose of advising the Secretary on matters of general policy in the administration of the medicaid program.

The committee believes that it is helpful from time to time to review the necessity for various advisory groups, and determine whether they should continue to function, or whether their responsibilities should be assumed by another existing advisory group.

Many of the areas of concern of the MAAC overlap those of the Health Insurance Benefits Advisory Council (HIBAC) under medicare. The similarities between medicare and medicaid are considerably greater and more important than the differences. Both are concerned with hospital, medical, skilled nursing facility care, and related care, as the major and most costly items of service provided. Patterns of payment and standards of care between the two programs are closely related. Further efforts to conform them even more closely, particularly in the area of long-term care, have been made by the committee in this bill, and by the Department. A single advisory group would avoid duplicative activity.

The committee has therefore approved a provision to terminate the Medical Assistance Advisory Council three months following enactment of H.R. 1. Of course the Secretary would still be free to appoint, as necessary, temporary ad hoc advisory groups to deal with specific medicaid areas of concern.

The Council's responsibility for advising the Secretary on matters of general policy affecting medicaid would be lodged with the Health Insurance Benefits Advisory Council.

Extension of 75 Percent Federal Matching for Medical Personnel Under Contract

(Sec. 282 of the bill)

Present law permits Federal financial participation at the 75-percent rate for the compensation of skilled professional medical personnel and staff directly supporting such personnel of the State agency or of any public agency involved in the administration of the medicaid program at the State or local level. Such personnel and staff include physicians; members of other health professions such as dentists, medical and psychiatric social workers, nurses, and pharmacists; other specialized personnel, such as research specialists and experts on medical costs.

Present law, however, provides only 50 percent Federal matching (the matching rate for general administration of the title XIX program) for such medical personnel in non-public organizations under contract to the single State agency administering the medicaid program. This limitation handicaps States in securing outside medical personnel on a contract basis with respect to medicaid functions.

The committee has authorized Federal matching under medicaid of 75 percent of the reasonable costs of compensating skilled medical personnel and direct supporting staff other than those of the State or other public agencies. The committee included a similar amendment in H.R. 17550 which was approved by the Senate.

States would thus be able, by contract arrangements, to use such professional personnel for independent professional and medical audits required with respect to patients in skilled nursing homes, mental institutions, and intermediate care facilities whose use might otherwise not be economical.

Increase in Maximum Federal Medicaid Amount for the Virgin Islands

(Sec. 271 of the bill)

Under present law, there is an annual ceiling of $650,000 on Federal matching funds for the Virgin Islands' medicaid program.

Over the past several years, there have been substantial increases in the unit costs of hospital and physicians' care in the Virgin Islands which are expected to increase further. There has also been an increase in medicaid eligibles. The committee believes the $650,000 maximum on medicaid payments to the Virgin Islands should be adjusted to reflect the impact of these factors.

The committee has approved an increase in the ceiling on Federal medicaid matching for the Virgin Islands from the present $650,000 to $1 million.

There would be no change in the 50 percent Federal matching rate.

The provision would be effective for fiscal year 1972 and each fiscal year thereafter.

100 Percent Federal Financing of Medicaid Nursing Home Survey and Inspection Costs

(Sec. 249B of the bill)

At present, Federal matching funds for inspection of skilled nursing facilities participating in the medicaid program are limited to 75 percent of necessary costs while reimbursement for inspection of medicare extended care facilities is 100 percent of necessary costs.

The President has recommended that survey and inspection costs of nursing facilities participating in the medicaid program be 100 percent federally financed.

Present State inspection systems for medicaid skilled nursing facilities and intermediate care facilities are less effective than they could be, due in part to the reduced reimbursement rate for these inspections which provides an incentive for States to concentrate on title XVIII reviews. Another result of this difference in reimbursement has been an inadequate number of skilled nursing facility and intermediate care facility inspectors. The committee believes that full Federal funding of the reasonable costs of nursing facility inspections would improve the present system of determining an institution's qualifications to participate in medicaid and medicare and serve to upgrade and standardize the quality of services provided by nursing facilities.

The committee has therefore added a provision to allow for 100 percent reimbursement for survey and inspection costs of skilled nursing facilities and intermediate care facilities under title XIX.

The amendment is effective January 1, 1972.

Definition of Physician Under Medicaid

(Sec. 280 of the bill)

Physicians' services are one of the mandatory items of health care services which a State must include in its medicaid program. The committee has amended section 1905(a)(5) of title XIX so as to include in the statute the definition of a physician, as originally intended, for purposes of this mandatory coverage as being a duly licensed doctor of medicine or osteopathy.

Services of other types of health care practitioners are authorized under other provisions of Section 1905(a). These other types of practitioner services would remain optional with the States in accordance with the clear intent of the committee originally expressed in 1965 with the enactment of medicaid.

This provision parallels a similar amendment added by the committee to H.R. 17550 and approved by the Senate.

Optometrists' Services Under Medicaid

(Sec. 212 of the bill)

Under present law a State can choose to provide optometrists' services as an optional service under its State plan. Some States, however, which had chosen to include this service as an optional medicaid service have dropped optometric care as a reimbursable service from their

plans, but specifically continued to provide for eye care which an optometrist is also licensed to provide under physicians' services, which is a mandatory service under title XIX.

The committee believes that such provisions circumvent the legislative intent as expressed in 1969.

Under the committee bill, a State which previously covered optometric services under medicaid and which, in its medicaid formal plan, *specifically* provides coverage for eye care under "physicians' services" which an optometrist is licensed to perform would also be required to reimburse such care whether provided by a physician or an optometrist; optometrists could not be excluded as potential providers in these cases.

Withholding of Federal Medicaid Matching Amounts for Certain Terminated Medicare Providers

(Sec. 290 of the bill)

At present there are many hospitals and extended care facilities which have withdrawn from participation in medicare without submitting cost reports to account for payments received under medicare or refunding overpayments, yet they continue to participate in the medicaid program and receive payments through that program without penalty.

This problem has been the subject of an extensive study and report by the Comptroller General in which he noted that improvements were needed at both the intermediary and Federal level of medicare to minimize overpayments. In addition he recommended that steps be taken to withhold other Federal payments, particularly under medicaid, to these institutions.

The committee amendment would authorize the Secretary of Health, Education, and Welfare to withhold (subsequent to sixty days advance notice to a State) future Federal financial participation in State medicaid payments to institutions which have withdrawn from medicare without refunding medicare overpayments or submitting cost reports to account for medicare payments to them during their participation in that program. The amendment is designed to recover funds which have been overpaid to terminated medicare providers and is not intended to penalize either the States or other title XVIII and/or title XIX providers. If the terminated providers in question enter into substantial negotiations with medicare, it is expected that the withdrawal of Federal financial participation for that provider would no longer apply.

Intermediate Care Facilities

(Secs. 297, 298, and 299 of the bill)

In order to provide a less costly institutional alternative to skilled nursing home care, the committee and the Congress approved in 1967 an amendment to title XI of the Social Security Act which authorized Federal matching for a new classification of care provided in "intermediate care facilities." The provision was intended to authorize a mechanism for appropriate placement of patients professionally determined to be in need of health-related supportive institutional care

but not that level of care provided by skilled nursing homes or mental hospitals.

Section 254 of the House bill provides for the transfer of the intermediate care facility program from title XI to title XIX, making these facilities subject to standards set by the Secretary and services in these facilities available to the medically indigent (at State option). This provision is now unnecessary as the section was, subsequent to House action on H.R. 1, separately enacted into law as part of Public Law 92–223, with modifications, and became effective January 1, 1972.

The committee has therefore deleted section 254 from the House bill. In its place, the committee has substituted several technical amendments which clarify the committee intent with respect to the ICF provisions of P.L. 92–223. These changes make clear that: (a) independent professional review of title XIX patients is required in all intermediate care facilities (section 298) and that (b) intermediate care facility services are to be covered for individuals age 65 or over in mental institutions, as well as inpatient hospital services and skilled nursing home services (section 297). In addition, language has been included which clarifies the designation of the base period for the maintenance of effort requirement pertaining to non-Federal expenditures with respect to patients in public institutions for the mentally retarded to be the four quarters immediately preceding the quarter in which the State elects to provide such services under title XIX. The committee limited this maintenance of effort requirement to the first three years the program is in effect under title XIX (the requirement would expire December 31, 1974 under the committee amendment) because the basic purpose of such maintenance of effort requirements is to assure against wholesale reductions in State effort with the introduction of Federal dollars at the outset of a program and not to provide a perpetual obligation to continue expenditures at or above some previous historic level which has no relationship to later circumstances. The committee expects that the maintenance of effort provision will be implemented in a manner which will not impede the relocation and transfer of persons in public institutions for the mentally retarded to non-institutional community settings, and between institutions in the State.

Training of Intermediate Care Facility Administrators

(Sec. 296 of the bill)

Until July 1, 1972, medicaid funds supported State training programs for waivered nursing home administrators designed to remove deficiencies in the qualifications of the administrators which would have otherwise prevented them from meeting State licensure requirements.

Public Law 92–223 authorized the transfer of the title XI intermediate care facility program to the title XIX program making possible the provision of ICF care as an optional service under a State medicaid plan. It also provided the Secretary with authority to set standards for ICF's. The committee has been advised by the Department that the ICF regulations to be issued by the Secretary will include standards for administrators of ICF's, and that a substantial portion of the administrators now operating ICF's may be unable to meet these standards.

The committee has therefore authorized expenditure of funds under title XIX for the two-year period ending June 30, 1974 to provide for supplemental training of ICF administrators who are unable to meet such standards as may be established in regulations by the Secretary.

Intermediate Care Services in States Which Do Not Have a Medicaid Program

(Sec. 292 of the bill)

Title XIX provides for Federal matching for medical services provided to low-income persons through State medicaid programs. States were required to have medicaid programs in effect as of January 1, 1970 or they could no longer receive Federal matching for medical vendor payments. To date, 52 jurisdictions have established programs under title XIX. Arizona and Alaska have not, as yet, chosen to participate in the program.

In 1967, the Congress made provision for Federal matching of payments for intermediate care facility services under title XI; as such, these payments were not considered to be medical vendor payments, and Federal matching was available independently of whether the State also had established a title XIX program. Public Law 92–223, provided, effective January 1, 1972, for the transfer of the intermediate care facility program to title XIX, making possible the provision of ICF care as an optional service under a State medicaid plan to both those eligible for cash assistance and the medically needy. Matching was no longer available for these services under the cash payment programs.

An unintended effect of P.L. 92–223 was to deny the possibility of Federal matching for intermediate care facility services in those States without medicaid programs. Therefore the committee has added an amendment to the bill to allow matching for intermediate care facility services under title XI in those States which did not, on January 1, 1972 have in effect an approved State plan under title XIX. Thus section 1121 would continue to apply to States without medicaid programs until the first day of the first month after January 1, 1972, that the State has in operation an approved State plan under title XIX.

Intermediate care facilities participating in a program in those States which do not have a title XIX program would be expected to meet the same basic standards prescribed by the Secretary for intermediate care facilities participating in the medicaid program.

Deletion of the Maintenance of Effort Requirement for Care for Individuals Age 65 and Over in Mental Hospitals

(Sec. 295 of the bill)

Current medicaid law restricts coverage of inpatient care in institutions for mental diseases to individuals 65 years of age or older who are otherwise eligible for medicaid. Under the provisions of the original statute, Federal matching for these services was tied to a requirement that the fiscal effort of State and local governments for these services be maintained. Specifically, section 1903(b)(1) required that States make a showing satisfactory to the Secretary that total expenditures from Federal, State, and local sources for mental health services

(including payments to or in behalf of individuals with mental health problems) under State and local public health and public welfare programs for a given quarter exceed the average of the total expenditures from such sources for such services for each quarter of the fiscal year ending June 30, 1965.

The committee believes that this maintenance of effort requirement has ceased to have any real effect because the base period for expenditures is now outdated. Continuation of the maintenance of effort requirement, even if updated, would not be desirable because it has fulfilled its basic purpose—to assure that there would not be substantial decreases in non-Federal effort with the introduction of Federal dollars for support of inpatient care for those 65 and older in institutions for mental diseases. The fiscal commitment of State and local governments to this health care area is now clearly established, and the possibility of a large-scale cut-back does not appear likely. The committee has, therefore, deleted the maintenance of effort requirement.

Disclosure of Ownership in Intermediate Care Facilities

(Sec. 299A of the bill)

Present legislation requires that information regarding the ownership of any facility participating as a skilled nursing home under medicaid be made available to the State licensing agency. Each person having a direct or indirect ownership interest of 10 percent or more in the home must be identified: in the case of those homes organized as a corporation, the identity of each officer and director of the corporation; and in the case of those homes organized as a partnership, the identity of each partner. Each facility is to report to the State agency any changes in the status of its ownership.

In the belief that standards for skilled nursing facilities under both medicare and medicaid should be uniform, the committee has provided elsewhere in this bill that this requirement should also be applied to skilled nursing facilities participating in the medicare program. Intermediate care facilities, not otherwise licensed as skilled nursing homes by a State, will make ownership information available to the Secretary of Health, Education, and Welfare.

Public Law 92–223 transferred the intermediate care facility program from title XI to title XIX effective January 1, 1972, and gave the Secretary authority to establish standards for intermediate care facilities.

Present law does not require disclosure of ownership of ICF's although these facilities have problems comparable to skilled nursing homes which disclosure is intended to help solve. The committee believes that it is desirable to have the disclosure of ownership requirement also apply to intermediate care facilities participating under medicaid and has approved an amendment to that effect.

4. PROVISIONS OF THE HOUSE BILL WHICH WERE DELETED BY THE COMMITTEE

Supplementary Medical Insurance Deductible

Under present law, a deductible equal to the first $50 of expenses incurred by a beneficiary for services of the type covered under the

supplementary medical insurance program is payable by the beneficiary.

Recognizing that medical costs have risen considerably since the beginning of the medicare program, the House concluded that it would be appropriate to increase the supplementary medical insurance deductible to $60 as of January 1, 1972.

The committee has deleted this provision (section 204) from the House bill. It is the committee's belief that the House provision does not take into account the fact that due to increased medical care costs, aged beneficiaries (according to the Department of Health, Education, and Welfare) are paying nearly as much out of pocket for medical care now as they were prior to medicare. The 20 percent coinsurance which they must pay—apart from any amounts in excess of medicare's "reasonable charge" determination—is being paid on substantially higher charges today than obtained in 1965. Finally, while it can be argued that deductibles and co-payments may deter unnecessary care, it may also be argued that such requirements can also serve to deter the seeking of necessary care. The committee believes that effective operation of the Professional Standards Review Organizations should serve to assure the medical necessity of services provided—an approach which appears preferable to imposing economic barriers to necessary as well as unnecessary care.

Limits on Payments for Skilled Nursing Home and Intermediate Care Facility Services

Section 225 of the House bill provided that for any calendar quarter beginning after December 31, 1971 the average per diem cost for skilled nursing homes and intermediate care facilities countable for Federal financial participation would be limited to 105 percent of such costs for the same quarter of the preceding year. It would also authorize the Secretary by regulation, to increase the percentage to take account of increases in per diem costs which result directly from increases in the Federal minimum wage, or which otherwise result directly from provisions of Federal law enacted (or amendments to Federal law made) after the date of enactment of H.R. 1.

The committee shares the concern of the House over rising expenditures for skilled nursing home and intermediate care facility services which are due to rising costs or inappropriate utilization. However, it does not believe that section 225 would be an equitable or administrable method of achieving cost control.

The committee believes that section 225 is inconsistent with an upgrading of care in facilities which may result in additional costs for the facility. The provision would be difficult to administer and inequitable in that it does not take into account many uncontrollable expenses and places an arbitrary limit, unrelated to services rendered, on payments to a facility. Furthermore, the Professional Standards Review provision approved by the committee should assure proper utilization of long-term care facilities, and over time should serve to effectively control costs for these services. In addition, the committee has approved an amendment which would require States to reimburse skilled nursing facilities and ICF's on a reasonable-cost related basis by July 1, 1974. The PSRO amendment, as well

as the requirement for a reasonable differential between average Statewide reimbursement rates for ICF and skilled nursing facility care, will also contribute to more equitable and rational payment for institutional care, while providing some control on cost increases.

The committee has therefore deleted the section from the House bill.

Determination of Reasonable Cost of Inpatient Hospital Services Under Medicaid and Maternal and Child Health Programs

Under regulations issued by the Secretary, States are required to reimburse hospitals for inpatient care under medicaid on the basis of the reasonable cost formula set forth in medicare, except on an experimental and demonstration basis.

Section 232 of the House-passed bill would allow States, generally, to develop their own methods and standards for reimbursement of the reasonable costs of inpatient hospital services, thereby giving them flexibility in working out payment arrangements with their hospitals. Reimbursement by the States would in no case exceed reasonable cost reimbursement as provided for under medicare.

The possibility exists that section 232 may provide the opportunity for States to reimburse hospitals under medicaid at less than the cost of medicaid services, and the committee feels that this would be undesirable.

The committee has, therefore, deleted the section.

Coverage of Ptosis Bars

Under medicare's supplementary medical insurance program, specific provision is made for the coverage of leg, arm, back, and neck braces, which includes a variety of devices used to support weak or deformed body members or to restrict motion in a diseased or injured part of the body. However, medicare does not pay for ptosis bars used to support the drooping eyelids of patients suffering from paralysis or atrophy of the muscles of the upper eyelid. The House bill would cover these devices in the same way as other supportive devices or appliances. No payment would be made for eyeglasses to which such devices may be attached. Based upon expert professional opinion that ptosis bars are generally ineffective and usually contraindicated, the committee has deleted the provision from the bill.

Prohibition Against Requiring Professional Social Workers in Extended Care Facilities Under Medicare

In order to participate as an extended care facility under the medicare program, institutions are now required to engage the services of a professional social worker. This requirement is not specified in the statute but was promulgated by the Secretary under his authority to establish conditions deemed necessary for the health and safety of patients. Some facilities have had difficulty obtaining such consultation, and where obtainable, the consultants have often been quite

expensive. To alleviate this problem, a provision was included in the House bill which would prohibit the Secretary from requiring provision of medical social services as a condition of participation for an extended care facility under medicare.

The committee bill would delete the House provision. Social services are potentially valuable in controlling and assuring proper utilization, since the social work personnel are primarily responsible for discharge planning. Just last year, subsequent to House approval of H.R. 1, the Joint Commission on Accreditation established a requirement that hospitals have social service units designed to facilitate discharge planning. Removal of the requirement to provide such services would not be in the best interests of either the medicare program or its beneficiaries.

Requirements for Nursing Home Administrators

Present law provides that a skilled nursing home which is receiving medicaid payments must be operating under the supervision of an administrator licensed by the State agency or board whose purpose it is to develop, impose, and enforce standards regarding the qualifications and training of individuals applying for such a license. The current provision also permits the appropriate State agency or board to grant a waiver with respect to any of its standards to individuals who served as an administrator for the calendar year immediately preceding the calendar year in which the requirements for a licensure program were first met by the State provided there is a training program operating in the State to enable individuals to meet the requirements necessary to obtain a license. The waiver authority, however, expired on June 30, 1972.

The House was concerned that persons who have worked as nursing home administrators should not be precluded from serving in this capacity because they fail to meet certain statutory requirements of the medicaid program. The House therefore amended present law to permit States to grant a permanent waiver from title XIX requirements for licensure to those individuals who served as nursing home administrators for the three-year period preceding the year the State established a licensure program.

The Finance Committee approved the licensure provision in 1967 as a means of upgrading the quality of personnel administering nursing homes. The committee believes that a permanent waiver in regard to licensure requirements would be inconsistent with and possibly detrimental to assuring patient care of proper quality and the emphasis on the professional upgrading of nursing home standards.

The committee has therefore deleted this provision (section 269) from the bill.

Termination of the National Advisory Council on Nursing Home Administration

Included in the Social Security Amendments of 1967 was a provision for the establishment of a National Advisory Council on

Nursing Home Administration whose purpose was to study, develop, and advise the Secretary of Health, Education, and Welfare and the States on issues related to qualifications, training, and licensure programs of nursing home administrators. The Council was scheduled to terminate on December 31, 1971.

After reviewing the operation of the Council, and since the Council had completed its work at a date earlier than that provided by statute, the committee included a provision in H.R. 17550 providing for termination of the Council as of December 31, 1970. The House included a similar provision (section 270) in H.R. 1. However, the Council expired by statute on December 31, 1971, and the amendment terminating the Council is now unnecessary.

5. ADDITIONAL MATTERS OF CONCERN TO THE COMMITTEE

Coordination of Regulatory Activities for Clinical Laboratories

At present, the Department of Health, Education, and Welfare regulates laboratory operations and performance under two different programs—the medicare program, administered by the Social Security Administration, and the program for regulating laboratories engaged in interstate commerce, administered by the Center for Disease Control of the Health Services and Mental Health Administration. The two Federal programs issue separate regulations, apply different standards, and are administered by different personnel. However, the committee has been informed that efforts have been undertaken by the Department to coordinate the activity of its components with respect to regulation of clinical laboratories.

In order to try to eliminate the dual operation in favor of a single approach, the committee expects that the Secretary of Health, Education, and Welfare will continue to initiate such administrative changes as might result in uniform standards and policies and the placing of responsibility for regulating interstate laboratories in one organizational component of the Department. The committee also expects that the Secretary will report to it not later than 6 months after enactment, concerning the changes initiated, and that he will recommend such legislative action, if any, which may be required to avoid duplication.

Outpatient Physical Therapy in Rural Communities

Under present law outpatient physical therapy services are covered under medicare only when furnished by participating hospitals, extended care facilities, home health agencies, clinics, rehabilitation agencies, and public health agencies. The participating provider may furnish outpatient physical therapy through employees or by making suitable arrangements for self-employed physical therapists to work under its supervision. Payment is permitted for services in a self-employed therapist's private office only where the participating organization is a public health agency and neither it nor the other participating providers in the area are able to furnish a full range of physical therapy procedures on an outpatient basis. This approach was adopted be-

cause of the probability that participating organizations which provide none of the services themselves would not be able to adequately supervise the services independent practitioners perform in their private offices. An exception was made in the case of public health agencies because they represent the only participating provider in many rural areas and they often are not able to provide physical therapy on their premises. These agencies have no choice but to rely on a local independent practitioner and his facilities to provide physical therapy to their patients.

While the committee supports this policy, it has come to the committee's attention that there are also some rural communities where the only participants in the medicare program are hospitals which do not provide physical therapy on their premises. The committee believes that the Secretary should accord such hospitals the same treatment accorded to public health agencies in order to assure that covered outpatient physical therapy is available to beneficiaries in these rural areas. The committee understands that some rural hospitals have already arranged for necessary physical therapy services to be provided to beneficiaries off their premises but in the community served by the hospital. If he has not already done so, it expects that the Secretary will validate such arrangements where they were reasonable under the circumstances.

Qualification of Home Health Agency

One of the statutory requirements for participation in medicare as a "home health agency" is that the agency must be "primarily engaged in providing skilled nursing services and other therapeutic services." It has come to the committee's attention that this requirement has been interpreted to mean that an agency which has only nurses on its staff may not participate in medicare as a home health agency even though the nurses may perform services in addition to nursing. In the committee's view, a home health agency which provides skilled nursing and other therapeutic services should not be disqualified from participating solely on the ground that it employs only skilled nurses to provide such services. The committee expects that the Secretary will take this view into account in determining an agency's eligibility to participate in medicare and medicaid as a home health agency.

Home Health Services

Home health services are presently covered under medicare only if they are provided by a qualified home health agency under an overall plan of treatment prescribed by a physician for a beneficiary who has a need for such services. Although there is no requirement that the coverage of home health services under medicaid be similarly limited, in fact the same requirements have also been applied. However, in some rural areas and small towns there are no home health agencies and only a few physicians to provide services over broad geographical areas. Some physicians in these areas call upon nurses to provide certain serv-

ices to homebound patients. Such services could be covered as "home health services" if provided by a qualified home health agency or as services "incident to a physician's service" where the physician actually accompanied the nurse. These services are, of course, services which the nurse is licensed to perform. In the absence of a home health agency, the only way they now may be paid for under medicare is for the physician to perform such services himself or to accompany his nurse to the patient's home.

The committee believes that these alternative arrangements for payment represent a highly uneconomical use of scarce physician manpower. The Secretary of Health, Education, and Welfare should waive the normal requirements with respect to coverage of health services performed in the patient's home, so as to cover certain added services where: (1) the service was individual or intermittent; (2) the service was rendered by a nurse or trained technician employed or engaged (under arrangements acceptable to the Secretary) by a visiting nurse association or similar organization or by a physician; (3) the service of such a professional was required for the care of the patient; (4) there was either no participating home health agency servicing the area or none servicing the area which could provide the service in a timely fashion; (5) the cost to the program is probably less than it would have been had the service been performed incident to a physician's services; and (6) the service is ordinarily provided in a manner which the Secretary finds appropriate. The Committee expects that similar services would also qualify for reimbursement as home health services under the medicaid program.

The committee suggests that the services covered by the waiver be limited to those services which could be covered if performed as a regular home health service or incident to a physician's service. Payment would be made at no more than the reasonable charge or reasonable cost, as appropriate, for such services.

Medicaid Benefit Cost Estimates Under Current Law and Senate Version of H.R. 1, Calendar Years 1973–77

In compliance with section 252(a) of the Legislative Reorganization Act of 1970, the following statement, provided by the Department of Health, Education, and Welfare, is made relative to the costs incurred in carrying out the medicaid provisions of this bill. With the exception of the item noted on the projected costs and savings, the committee and the Department reasonably agree.

1. Base program costs for medicaid are derived from estimates of medical vendor payments, projected from the base of the fiscal year 1973 expenditures contained in the President's budget, and adjusted to reflect the inclusion of services in intermediate care facilities (transferred from title XI to title XIX, effective January 1, 1972). Three basic factors influence the estimates of title XIX costs over the 5-year period: inflation in medical care costs, growth in the eligible population (generally reflecting the increase in the cash assistance population), and changes in patterns of utilization. The rates of inflation assumed vary somewhat by type of service; they are in line with the

policies of the wage-price guidelines, and parallel those used by the Social Security actuaries in estimating future costs under title XVIII.

2. The current law estimate is based on assumptions of continuation of current programs for cash assistance for families and needy adults, and continuation of current medicaid. The estimates are based on assumptions of slightly increased use of noninstitutional services in response to program policies and initiatives planned over the 5-year period.

3. Estimates of the impact of the Senate version of H.R. 1 account only for the impact of the title II provisions. Offsets occurring under title XIX because of changes in title XVIII coverage have been included. It should be noted, however, that the impact of extending medicaid to employment program families (who are ineligible under the terms of the current program because of the presence of an employed father in the home) have not been included, because they are more properly reflected as a cost resulting from title IV of the bill. Similarly, no estimate has been prepared of the impact of the provision for treatment of alcoholics and addicts under title XV of the Social Security Act. In general, the cost implications of that provision will consist of transfers from one program (in this case title XIX) to another, the title XV program.

4. It should be noted that the cost estimates of the Senate version of H.R. 1 are not directly comparable to similar estimates of the impact of the House version on H.R. 1. This is the result of several factors:

(a) The projections of program costs prepared in conjunction with the House version of H.R. 1 were derived from a slightly different base than was used for estimating purposes for the Senate bill. This reflects the fact that the estimates prepared in conjunction with the Senate version of H.R. 1 were prepared nearly one full year later, and more recent data were available upon which to base program estimates. The projection of current program costs prepared in conjunction with this bill are therefore more recent and more accurate.

(b) The base figures used for preparation of estimates for this bill included expenditures for intermediate care facilities, reflecting the transfer of this service to title XIX.

(c) The 20 percent increase in social security benefits recently enacted into law caused some reduction in the size of the population eligible for medicaid, and lowered slightly the base of medicaid expenditures.

(d) The estimates prepared in conjunction with the House bill were fiscal year figures. The figures accompanying this bill are on a calendar year basis.

(e) The figures prepared in conjunction with the Senate bill represent total title XIX expenditures (medical vendor payments and administrative costs). The estimates prepared in conjunction with the House bill represented medical vendor payments only; administrative costs were not included. In general, administrative costs are approximately 5 percent of medical vendor payments under title XIX.

(f) The effective dates of many of the provisions in the Senate bill are later than those contained in the House bill. This accounts for a substantial difference in the estimate of the impact of the two bills in the initial years.

IMPACT OF SENATE VERSION OF H.R. 1 ON FEDERAL MEDICAID COSTS, CALENDAR YEARS 1973–77

[Millions of dollars]

	Federal fiscal impact	
	Calendar year 1973	1974
Section (from House bill):		
201 Coverage of disabled under medicare	−30	−67
207 Comprehensive health care	−74	−162
208 Cost sharing under medicaid	−62	−62
209 Determination of payments	+79	+29
231 Maintenance of effort	[1]−570	[1]−640
271 Increased matching to Puerto Rico	+10	+10
New provisions:		
Drugs under medicare	−24	−51
Coverage of mentally ill children	+52	+120
Level of care requirements	−13	−14
75 percent matching on contract medical personnel	+5	+6
100 percent reimbursement-SNH inspectors	+19	+21
Reasonable cost related reimbursement		+17
Total Federal fiscal impact	[1]−608	[1]−793

[1] The committee does not agree with the Department concerning the estimate of savings. Because of the substantial savings accruing to States under various provisions of the bill, the committee does not anticipate any wholesale cutbacks by States in their medicaid programs. The purpose of the amendment involved was to permit States to make orderly (and often short-term) adjustments in their medicaid programs from time to time as circumstances dictated. Thus, the calendar year 1973 total of savings should be reduced by about $500,000,000 and that for 1974 by some $600,000,000.

MEDICAID COST ESTIMATES, CURRENT LAW AND SENATE VERSION OF H.R. 1, CALENDAR YEARS 1973–77

[Millions of dollars]

Calendar year	1973	1974	1975	1976	1977
Current law	5,655	6,559	7,542	8,579	9,674
H.R. 1, Senate version	5,047	5,766	6,679	7,609	8,593
Federal savings	[1]608	[1]793	[1]863	[1]970	[1]1,081

[1] Committee does not agree. See footnote on preceding table.

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